COUNTY OF SONOMA HEALTH PLAN
SUMMARY PLAN DESCRIPTION

Effective June 2011

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Claims Administered by:
ANTHEM BLUE CROSS on behalf of ANTHEM BLUE CROSS LIFE AND HEALTH
& CVS/CAREMARK

TABLE OF CONTENTS

This Summary Plan Description provides a summary of your benefits, limitations and other plan provisions that apply to you and replaces and supersedes all other Summary Plan Descriptions previously issued.

Employees, retirees and covered dependents ("beneficiaries") are referred to in this booklet as "you" and "your". The *plan administrator* is referred to as "we", "us" and "our".

All italicized words have specific definitions. These definitions can be found either in the specific section or in the DEFINITIONS section of this booklet.

Please read this Summary Plan Description ("*plan description*") carefully so that you understand all the benefits your *plan* offers. Keep this Summary Plan Description handy in case you have any questions about your coverage.

In cases where there is a conflict in the benefit description material distributed, or information from Anthem Blue Cross or the Customer Service personnel and this SPD, the wording in the SPD shall govern.

GENERAL PLAN INFORMATION

This Plan Description, including any amendments, is a summary of your benefits. All benefits are subject in every way to the entire plan. No agent or employee has any authority to change any of the terms, or waive the provisions of the plan. This plan is intended to comply with all provisions of the Patient Protection and Affordable Care Act of 2010. Any provision of this plan that may be determined to not be in compliance will be administered per the requirements of the Act.

Anthem Blue Cross Life and Health administers County of Sonoma Health Plans for medical benefits and CVS/Caremark for prescription drug benefits. The plan year runs on a June 1 to May 31 annual cycle.

For information regarding your medical claims, eligibility for benefits or to access a list of Anthem Blue Cross Life and Health preferred providers, go to www.anthem.com/ca. On the website, click on "Local California Providers" when selecting the plan to conduct a provider search. If you do not have Internet access, contact Anthem Blue Cross Life and Health Customer Service at 800- 759-3030. Members living out of California can also use the Anthem Blue Cross Life and Health website (www.anthem.com/ca) and click on "BlueCard PPO" to find a provider outside of California.

For information regarding your prescription drug claims, eligibility for benefits or to access a list of CVS/Caremark participating pharmacies, go to www.caremark.com. If you do not have Internet access, contact Caremark Member Services at 1-800-966-5772.

HOW TO USE THIS DOCUMENT

There are two County Health Plans:

1. County Health Plan PPO
2. County Health Plan EPO

This booklet describes how the plan works and provides details of your benefits, regardless of which County Health Plan you enrolled in. The benefits described in pages 4 – 51 apply to all members of both County Health Plan designs.

Both of the County Health Plans has its own customized design and benefit levels. It is very important that you read the additional information regarding your benefit levels (e.g., Deductible amounts, Co-Payments/Co-insurance Amounts, Out-Of-Pocket Amounts and Medical Benefit Maximums), included in the Appendices of this booklet.

DEDUCTIBLES, CO-PAYMENTS/CO-INSURANCE, OUT-OF-POCKET AMOUNTS AND MEDICAL BENEFIT MAXIMUMS

After subtracting any applicable deductible and your co-payment/co-insurance, benefits will be paid up to the amount of the *covered expense,* not to exceed the applicable maximums. The benefit levels are set forth in one of the following two Appendices, depending upon your specific County Health Plan Design:

Appendix 1 – County Health Plan **PPO**

Appendix 2 – County Health Plan **EPO**

DEDUCTIBLES

For all covered expenses, the member is responsible to satisfy the deductible before the plan pays benefits, unless it is specifically stated the deductible is otherwise waived.

Benefit Year Deductibles. Each benefit plan *year*, you will be responsible for satisfying the Individual Benefit Year Deductible before benefits are paid. If *beneficiaries* of an enrolled family pay the entire deductible in a *year* equal to the Family Deductible, the Benefit Year Deductible for all family members will be considered to have been met.

CO-PAYMENTS/CO-INSURANCE

After you have satisfied any applicable deductible(s), your Co-Payment/Co-Insurance will be subtracted from the amount of *covered expense* remaining.

For Co-Insurance that is a percentage of the *covered expense*, the applicable percentage will be applied to the amount of *covered expense* remaining after any deductible has been met. This will determine the dollar amount of your Co-Insurance.

OUT-OF-POCKET AMOUNTS

Satisfaction of the Out-Of-Pocket Amount. If, after you have met your Benefit Year Deductible, you pay Co-Payments/Co-Insurance equal to your Out-Of-Pocket Amount per *beneficiary* during a *benefit year*, you will no longer be required to make Co-Payments/Co-Insurance for any *covered expense* you incur during the remainder of that *year*.

Charges That Do Not Apply Toward the Out-Of-Pocket Amount. The following charges will not be applied toward satisfaction of an Out-Of-Pocket Amount:

- Deductibles
- Physician office visit co-payment
- Prescription drug co-payment
- Expenses that are incurred for non-covered services or supplies, or which are in excess of the amount of *covered expense*.

MEDICAL BENEFIT MAXIMUMS

The *plan* does not make benefit payments for any *beneficiary* in excess of any of the Medical Benefit Maximums. Refer to one of the Appendices for specific information about the Medical Benefit Maximums that apply to you.

TYPES OF PROVIDERS

Please read the following information so you will know from whom or what group of providers health care may be obtained. If you have special health care needs, you should carefully read those sections that apply to those needs. The meanings of words and phrases in italics are described in the section of this booklet entitled definitions.

There are two kinds of *providers* in this *plan:*

- **Participating Providers (PPO).** "*Participating providers"* are primarily *hospitals* and *physicians* who participate in

the preferred provider organization program (PPO), called the Prudent Buyer Plan or (2) participate in a Blue Cross and/or Blue Shield Plan network applicable outside California, and have agreed to provide *beneficiaries* with health care services at a discounted rate. *Participating providers* also refer to pharmacies that participate in the CVS/Caremark network.

- **Non-Participating (non-PPO) Providers.** "*Non-participating providers"* are *hospitals* and *physicians* that have not agreed to participate in the Prudent Buyer Network or do not participate in a Blue Cross and/or Blue Shield Plan network outside California. They have not agreed to the *negotiated rates* and other provisions. *Non-participating providers* also refer to pharmacies not participating in the CVS/Caremark network.

A directory of *Participating Providers* is available at **www.anthem.com/ca**, or by calling the toll-free Provider Access number (1-800-759-3030) to find a *participating provider* in your area.

A directory of CVS/Caremark Participating Pharmacies is available at **www.caremark.com**, or by calling the toll-free member services number (1-800-966-5772) to find a *participating provider* in your area.

Under this *plan*, there is no requirement to select a primary care physician (PCP) or to obtain a referral or prior authorization before visiting an OB/GYN provider.

SUBMITTING CLAIMS FOR REIMBURSEMENT OF NON-PARTICIPATING PROVIDERS

For medical services rendered in California by *non-participating providers* send claims to:

ANTHEM BLUE CROSS LIFE AND HEALTH
P.O. Box 60007
Los Angeles, CA 90060-0007

For out-of-state medical claims, contact Customer service for the claims office address. Out-of-state claims must be sent to the Blue Plan of the state in which services were rendered.

For prescription drugs dispensed by *non-participating providers*, send claims to:

CVS/CAREMARK
P.O. Box 52116
Phoenix, AZ 85072

HOW A COVERED EXPENSE IS DETERMINED

The benefits of this *plan* are provided only for those services that are considered *medically necessary* as defined in the plan description. The fact that a physician prescribes or orders the service does not, in itself, make it *medically necessary* or a *covered expense*. Consult this booklet or telephone the number shown on your identification card if you have any questions regarding whether services are covered.

This *plan* contains many important terms (such as "medically necessary" and "covered expense") that are defined in the definitions section. When reading this booklet, consult the definitions section to be sure that you understand the meanings of these italicized words.

All benefits are subject to coordination with benefits under other insurance plans. The benefits of this *plan* may be subject to the REIMBURSEMENT FOR ACTS OF THIRD PARTIES section.

The *plan* will pay for *covered expenses* you incur. A charge is incurred when the service or supply giving rise to the charge is rendered or received. *Covered expenses* for medical benefits are based on a maximum charge for each covered service or supply that will be accepted for each different type of provider. The *covered expense* amount is not the amount a provider bills for the service.

Participating Providers. The maximum *covered expense* for services provided by a *participating provider* will be the lesser of the billed charge or the *negotiated rate*. *Participating providers* have agreed not to charge you more than the *negotiated rate* for covered services. When you choose a *participating provider,* you will not be responsible for any amount in excess of the *negotiated rate*.

If you go to a *hospital* that is a *participating provider,* you should not assume all providers in that *hospital* are also *participating providers*. To receive the greater benefits afforded when a *participating provider* provides covered

services, you should request that all your provider services be performed by *participating providers* whenever you enter a *hospital*.

Non-Participating Providers and Other Health Care Providers. The maximum *covered expense* for services provided by a *non-participating* or *other health care provider* will always be the lesser of the billed charge or:

(1) for a *physician,* the *plan's* scheduled allowance as determined annually by the *claims administrator* based on charges which fall within the common range of fees billed by a majority of *physicians* for a procedure in a given geographic region. If it exceeds that range, the expense must be justified based on the complexity or severity of treatment for a specific case.

(2) for other than a *physician,* the charge determined by the *claims administrator* not to be excessive based on the circumstances of the care provided, including: (a) level of skill; experience involved; (b) the prevailing or common cost of similar services or supplies; and (c) any other factors which determine value. *Covered expenses* for *emergency services* rendered in a *hospital* emergency room are determined based on a formula set forth in Health Care Reform legislation.

You will be responsible for any billed charge that exceeds the *covered expense*.

You will always be responsible for expenses incurred that are not covered under this *plan*.

CONDITIONS OF COVERAGE

The following conditions of coverage must be met for expenses incurred to be considered as a *covered expense*.

1. You must incur the expense while you are covered under this *plan*. Expenses are incurred on the date you receive the service or supply for which the charge is made.
2. The expense must be for a medical service or supply furnished to you as a result of illness or injury or pregnancy, unless a specific exception is made.
3. The expense must be for a medical service or supply included in the section entitled "MEDICAL CARE THAT IS COVERED". Additional limits on *covered expenses* are included in the Appendices.
4. The expense must not be for a medical service or supply listed in the section entitled "MEDICAL CARE THAT IS NOT COVERED". If the service or supply is partially excluded, then only that portion which is not excluded will be considered a *covered expense*.
5. The expense must not exceed any of the maximum benefits or limitations of this *plan*.
6. Any services received must be those that are regularly provided and billed by the provider. In addition, those services must be consistent with the illness, injury, degree of disability and your medical needs. Benefits are provided only for the number of days required to treat your illness or injury.
7. All services and supplies must be ordered by a *physician*.

MEDICAL CARE THAT IS COVERED

The *plan* will provide benefits for the following services and supplies:

Acupuncture

Acupuncture treatment to treat intractable pain only or conditions resulting therefrom, including a patient history visit, physical examination, treatment planning and treatment evaluation, electroacupuncture, cupping and moxibustion. No benefits will be payable unless services are performed by or referred by a M.D.

Allergy Treatment

Testing, cost of serum, and injections.

Ambulance

The following ambulance services are covered:

1. Base charge, mileage and non-reusable supplies of a licensed ambulance company for ground service to transport you to and from a *hospital*.
2. Emergency services or transportation services that are provided to you by a licensed ambulance company as a result of a "911" emergency response system request for assistance if you believe you have an *emergency* medical condition requiring such assistance.
3. Base charge, mileage and non-reusable supplies of a licensed air ambulance company to transport you from the area where you are first disabled to the nearest *hospital* where appropriate treatment is provided if, and only if, such services are *medically necessary* and ground ambulance service is inadequate.
4. Monitoring, electrocardiograms (EKGs; ECGs), cardiac defibrillation, cardiopulmonary resuscitation (CPR) and administration of oxygen and intravenous (IV) solutions in connection with ambulance service. An appropriately licensed person must render the services.

*If you have an *emergency* medical condition that requires an emergency response, please call the "911" emergency response system if you are in an area where the system is established and operating.

Blood

Blood transfusions, including blood processing and the cost of unreplaced blood and blood products. Charges for the collection, processing and storage of self-donated blood are covered, but only when specifically collected for a planned and covered surgical procedure.

Breast Cancer

Services and supplies provided in connection with the screening for, diagnosis of, and treatment for breast cancer, including:

1. Routine and diagnostic mammogram examinations.
2. Mastectomy and lymph node dissection; complications from a mastectomy including lymphedema.
3. Reconstructive surgery performed to restore and achieve symmetry following a *medically necessary* mastectomy.
4. Breast prostheses following a mastectomy (see "Prosthetic Devices").

Cancer Clinical Trials

Coverage is provided for services and supplies for routine patient care costs, as defined below, in connection with phase I, phase II, phase III and phase IV cancer clinical trials if all of the following conditions are met:

1. The treatment provided in a clinical trial must either:
   a. Involve a drug that is exempt under federal regulations from a new drug application, or
   b. Be approved by (i) one of the National Institutes of Health, (ii) the federal Food and Drug Administration in the form of an investigational new drug application, (iii) the United States Department of Defense, or (iv) the United States Veteran's Administration.
2. You must be diagnosed with cancer to be eligible for participation in these clinical trials.
3. Participation in such clinical trials must be recommended by your *physician* after determining participation has a meaningful potential to benefit the *beneficiary*.
4. For the purpose of this provision, a clinical trial must have a therapeutic intent. Clinical trials to just test toxicity are not included in this coverage.

Routine patient care costs means the costs associated with the provision of services, including drugs, items, devices and services that would otherwise be covered under this *plan*, including health care services that are:

1. Typically provided absent a clinical trial.
2. Required solely for the provision of the investigational drug, item, device or service.

3. Clinically appropriate monitoring of the investigational item or service.
4. Prevention of complications arising from the provision of the investigational drug, item, device, or service.
5. Reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including the diagnosis or treatment of the complications.

Routine patient care costs do not include the costs associated with any of the following:

1. Drugs or devices not approved by the federal Food and Drug Administration that are associated with the clinical trial.
2. Services other than health care services, such as travel, housing, companion expenses and other nonclinical expenses that you may require as a result of the treatment provided for the purposes of the clinical trial.
3. Any item or service provided solely to satisfy data collection and analysis needs not used in the clinical management of the patient.
4. Health care services that, except for the fact they are provided in a clinical trial, are otherwise specifically excluded from this *plan*.
5. Health care services customarily provided by the research sponsors free of charge to *beneficiaries* enrolled in the trial.

Chemotherapy

Chemotherapy services can be rendered in a hospital, office or home setting. Chemotherapy is the use of chemical or biological antineoplastic agents (drugs) to treat malignant diseases. Chemotherapy can be delivered by any of the following methods:

- Orally: Prescription drug in pill form taken by mouth.
- Parenteral: Medication delivered by injection either intravenous, intramuscular and/or subcutaneous.
- Infusion Pump: Medication delivered on a continuous basis through a pump, either a portable pump or an implantable pump.
- Arterial perfusion: Medication delivered by injection through an artery.
- Intracavitary: Medication injected into the space within an organ (e.g.,bladder).
- Intrathecal: Medication injected into tissue that surround internal organs (e.g., peritoneum).
- NOTE: Chemotherapy utilizing antineoplastic agents (drugs) that are not FDA approved is *investigational* and therefore excluded from coverage.

Chiropractic Services (See Physical Therapy, Physical Medicine, including Chiropractic Services)

Contraceptives

Services and supplies provided in connection with the following methods of contraception:

- Oral contraceptives
- Injectable drugs and implants for birth control, administered in a *physician's* office, if *medically necessary*.
- Intrauterine contraceptive devices (IUDs) and diaphragms, dispensed by a *physician* if *medically necessary*.
- Professional services of a *physician* in connection with the prescribing, fitting, and insertion of intrauterine contraceptive devices or diaphragms.

If your *physician* determines that none of these contraceptive methods are appropriate for you based on your medical or personal history, coverage will be provided for another prescription contraceptive method that is approved by the Food and Drug Administration (FDA) and prescribed by your *physician*.

Dental Care

Services of a *physician* (M.D.) or dentist (D.D.S. or D.M.D.) solely to treat an *accidental injury* to natural teeth. Coverage shall be limited to only such services that are *medically necessary* to repair the damage done by *accidental injury* and/or restore function lost as a direct result of the *accidental injury*. Damage to natural teeth due to chewing or biting is not *accidental injury*.

Diabetes

Services and supplies provided for the treatment of diabetes, including:

1. The following equipment and supplies:
    a. Blood glucose monitors, including monitors designed to assist the visually impaired, and blood glucose testing strips.
    b. Insulin pumps.
    c. Pen delivery systems for insulin administration (non-disposable).
    d. Podiatric devices, such as therapeutic shoes and shoe inserts, to treat diabetes-related complications.
    e. Visual aids (but not eyeglasses) to help the visually impaired to properly dose insulin.

    These covered equipment and supplies are covered under this *plan's* benefits for durable medical equipment (see "Durable Medical Equipment").
2. The following items are covered as medical supplies:
    a. Insulin syringes, disposable pen delivery systems for insulin administration. Charges for insulin and other prescriptive medications are covered under the *plan's* "Prescription Drug" benefits.
    b. Testing strips, lancets, and alcohol swabs.

Diagnostic Services

Outpatient diagnostic radiology, laboratory services, pre-admission testing, non-routine mammography. See also Cancer Screening Tests and Preventive Care in the Appendices.

Durable Medical Equipment

Rental or purchase of dialysis equipment; dialysis supplies; pediatric asthma equipment and supplies; oxygen and related respiratory therapy supplies; hearing aids, limited to one per ear every 36 months. Rental or purchase of other medical equipment and supplies that are:

1. Of no further use when medical needs end;
2. For the exclusive use of the patient;
3. Not primarily for comfort or hygiene;
4. Not for environmental control or for exercise; and
5. Manufactured specifically for medical use.

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The *claims administrator* will determine whether the item satisfies the conditions above. Any payment, which exceeds $1,000 for a rental or purchase of durable medical equipment, will require prior authorization. (See MEDICAL MANAGEMENT PROGRAMS: AUTHORIZATION PROGRAM.)

Food Products

Special food products and formulas that are part of a diet prescribed by a *physician* for the treatment of phenylketonuria (PKU). These items will be covered as medical supplies.

Hemodialysis Treatment

Dialysis for the treatment of acute kidney failure, end-stage kidney disease and chronic renal disease.

Home Health Care

The following services provided by a *home health agency:*

1. Services of a registered nurse or licensed vocational nurse under the supervision of a registered nurse or a *physician*.
2. Services of a licensed therapist for physical therapy, occupational therapy, speech therapy, or respiratory therapy.
3. Services of a medical social service worker.
4. Services of a health aide who is employed by (or who contracts with) a *home health agency*. Services must be ordered and supervised by a registered nurse employed by the *home health agency* as professional coordinator. These services are covered only if you are also receiving the services listed in 1 or 2 above.
5. *Medically necessary* supplies provided by a *home health agency*.

Home health care services are subject to prior authorization to determine medical necessity. Please refer to MEDICAL MANAGEMENT PROGRAM: AUTHORIZATION PROGRAM for information on how to obtain the proper reviews.

Home health care services are not covered if received while you are receiving benefits under the "Hospice Care" provision of this section.

Home Infusion Therapy

The following services and supplies when provided by a *home infusion therapy provider* in your home for the intravenous administration of your total daily nutritional intake or fluid requirements, medication related to illness or injury, chemotherapy, antibiotic therapy, aerosol therapy, tocolytic therapy, special therapy, intravenous hydration, or pain management:

1. Medication, ancillary medical supplies and supply delivery, (not to exceed a 14-day supply); but medication which is delivered but not administered is not covered;
2. Pharmacy compounding and dispensing services (including pharmacy support) for intravenous solutions and medications;
3. Hospital and home clinical visits related to the administration of infusion therapy, including skilled nursing services including those provided for: (a) patient or alternative caregiver training; and (b) visits to monitor the therapy;
4. Rental and purchase charges for durable medical equipment are covered under “Durable Medical Equipment”
5. Laboratory services to monitor the patient's response to therapy regimen.

Home infusion therapy provider services are subject to prior authorization to determine medical necessity. See MEDICAL MANAGEMENT PROGRAMS: AUTHORIZATION PROGRAM for details.

Hospice Care

You must be suffering from a terminal illness for which the prognosis of life expectancy is six months or less, as certified by your *physician* and submitted to the *claims administrator*.

Your *physician* must consent to your care by the *hospice* and must be consulted in the development of your treatment plan. The *hospice* must submit a written treatment plan to the *claims administrator* every 30 days.

The *plan* will pay up to a maximum of **$3,000** during your lifetime for:

1. Room and board charges in an inpatient *hospice* unit, limited to a maximum payment of **$150** per day.
2. Services of a registered nurse, licensed practical nurse and licensed vocational nurse.

3. Services of a licensed therapist for physical therapy, occupational therapy, speech therapy and respiratory therapy.
4. Medical social services.
5. Services of a home health aide.
6. Dietary and nutritional guidance. Nutritional support such as intravenous feeding or hyperalimentation.
7. Drugs and medicines approved for general use by the Food and Drug Administration that are available only if prescribed by a *physician*.
8. Medical supplies. Oxygen and related respiratory therapy supplies.
9. Bereavement counseling for your family, up to a maximum of **$200** during your lifetime.
10. Palliative care (care which controls pain and relieves symptoms, but does not cure) which is appropriate for the illness.

Hospital

1. Inpatient services and supplies, provided by a *hospital*. *Covered expense* will not include charges in excess of the *hospital's* prevailing two-bed room rate unless your *physician* orders, and the *claims administrator* authorizes, a private room as *medically necessary*. All inpatient services are subject to prior authorization to determine medical necessity. Please refer to MEDICAL MANAGEMENT PROGRAMS for information on how to obtain the proper reviews.
2. Services in *special care units*.
3. Outpatient services and supplies provided by a *hospital,* including outpatient surgery.

Immunizations/Inoculations

Immunizations/inoculations, subject to the following limitations:

Diphtheria, pertussis and tetanus (DPT) – once every ten years after pediatric immunization

Polio – once in lifetime after pediatric immunization

Mumps – Once, if not previously immunized

Rubella – once, per lifetime

Gamma globulin – upon recommendation by Physician

Hepatitis B – once every 5 years for individuals in a high-risk category, subject to prior authorization See MEDICAL MANAGEMENT PROGRAM: AUTHORIZATION PROGRAM for details.

Varicella zoster

Infertility

Diagnostic services and surgical repair only.

Maternity and Pregnancy Care (*Subscriber, Spouse or Domestic Partner* Only)

1. All medical benefits when provided for maternity or pregnancy care, including diagnosis of genetic disorders in cases of high-risk pregnancy. Inpatient *hospital* benefits in connection with childbirth, including services of a Certified Nurse Midwife (CNM), will be provided for at least 48 hours following a normal delivery or 96 hours following a cesarean section, unless the mother and her *physician* decide on an earlier discharge.
2. Medical *hospital* benefits for routine nursery care of a newborn *child and* expenses incurred for circumcision, if the *child's* natural mother is a subscriber, enrolled *spouse* or *domestic partner*.

Mental Health (Refer to Appendices for specific benefit levels, based on the CHP in which you are enrolled)

Covered services shown below for the treatment of *mental or nervous disorders*, provided such services offer a reasonable expectation of improvement, and are the lowest level of care consistent with safe medical practice.

1. Inpatient *hospital* services as stated in the "Hospital" provision of this section. All inpatient services are subject to prior authorization to determine medical necessity. Please refer to MEDICAL MANAGEMENT PROGRAMS for information on how to obtain the proper reviews.
2. Visits to a *day treatment center*.
3. *Physician* visits during a covered inpatient *stay.*
4. *Physician, Psychologist, Marriage & Family Therapist and Licensed Clinical Social Worker* visits for outpatient psychotherapy or psychological testing for the treatment of *mental or nervous disorders*. *Physician* visits for rehabilitative care (such as physical therapy) for the treatment of *mental or nervous disorders*.

Organ and Tissue Transplants

Services provided in connection with a non-*experimental or investigational* organ or tissue transplant, if you are: (1) the organ or tissue recipient; or (2) the organ or tissue donor.

If you are the recipient, an organ or tissue donor who is not a *beneficiary* is also eligible for services as described. Benefits are reduced by any amounts paid or payable by that donor's own coverage.

Covered expense does not include charges for services received without first obtaining prior authorization from the *claims administrator*, or which are provided at a facility other than an approved transplant center. See MEDICAL MANAGEMENT PROGRAMS: AUTHORIZATION PROGRAM for details.

Transportation/Accommodations for Organ and Tissue Transplants

- When preauthorized by the *claims administrator*, travel benefits for medical care received away from home may be payable (e.g. pre-operative work-up, transplant operation and post-transplant treatment phases). The maximum *plan* benefit for travel expenses for the patient (and where necessary for the patient's well-being for one family member or travel companion) is $10,000 per transplant. Reimbursement is available as follows:

  100% of the cost for round trip "coach" airfare;

  Up to an additional maximum of $200 per day for lodging incurred primarily for and essential to the receipt of medical care;

  Necessary travel expenses related to receiving medical care, such as for a taxi, subway, train will be reimbursed at the face value indicated on the receipt subject the $10,000 benefit maximum;

  The *plan* will reimburse either (a) actual operating expenses incurred when your personal car is used to obtain medical care or (b) mileage for use of your personal car for medical care with reimbursement up to the IRS maximum allowance, adjusted periodically (e.g. for 2010: $0.16.5).

  Receipts are required for all lodging and travel expenses submitted for consideration for reimbursement.

  The following expenses will not be reimbursed by the *plan*: meals, car rentals, telephone calls, personal care items such as shampoo, and expenses for persons other than the patient and his/her designated family member/travel companion.

Pediatric Asthma Equipment and Supplies. The following items when required for the *medically necessary* treatment of asthma in a dependent *child*:

1. Nebulizers, including face masks and tubing.
2. Inhaler spacers and peak flow meters.

These items are covered under the *plan's* medical benefits and are not subject to any limitations or maximums that apply to coverage for durable medical equipment, if any, (see "Durable Medical Equipment").

Physical Therapy, Physical Medicine, including Chiropractic Services

The following services provided by a *physician* under a treatment plan:

- Physical therapy, physical medicine and chiropractic services provided on an outpatient basis for the treatment of illness or injury including the therapeutic use of heat, cold, exercise, electricity, ultra violet radiation, manipulation of the spine, or massage for the purpose of improving circulation, strengthening muscles, or encouraging the return of motion. (This includes many types of care that are customarily provided by chiropractors, physical therapists and osteopaths.)
- Benefits are not payable for care provided to relieve general soreness or for conditions that may be expected to improve without treatment. For the purposes of this benefit, the term "visit" shall include any visit by a *physician* in that *physician's* office, or in any other outpatient setting, during which one or more of the services covered under this limited benefit are rendered, even if other services are provided during the same visit.

Prescription Drug

The Plan covers both generic and brand name prescription drugs. You can fill a prescription at a pharmacy that is part of a network of participating CVS/Caremark pharmacies or through a mail order service. You pay a co-payment depending on whether the drug is generic or brand-name. (For PPO and EPO plan members, you pay different co-payments depending on whether or not the brand name drug is preferred or non-preferred according to CVS/Caremark. The list of preferred vs. non-preferred drugs are updated from time to time, so you may want to review it every so often to see if certain drugs have been added or dropped from the plan's preferred list. To see if a particular drug is on the plan's preferred list, call 1-800-966-572*.* When you have your prescription filled at one of the retail pharmacies that participates in the CVS/Caremark network, you receive the greater of 34-day supply or a 100-unit dose after you pay your co-payment.

For prescription medicines associated with a chronic condition or for maintenance prescriptions, you must use the mail order service. When you order your prescription drugs through the mail, you can receive up to a 90-day supply after you pay your co-payment. To fill a prescription through the mail order program, complete a mail order drug form (www.caremark.com) and return it along with your prescription to the address below:

Mail order address: P.O. Box 659541, San Antonio, TX 78265-9541

You can also begin using the mail order service by calling Caremark's Fast Start program at 1-866-465-2501. When you call Caremark's Fast Start program you will need to provide the name of the medication and the name of the prescribing doctor.

Covered Prescription Drugs

- All drugs prescribed by a Physician that require a prescription either by federal or state law, except the drugs listed under medical care that is not covered below.
- Oral contraceptives.
- Diabetic care. Disposable blood/urine glucose/acetone testing agents, disposable insulin needless/syringes, insulin, and lancets.
- Tretinoin topical (e.g. Retin-A) for individuals through the age of 25 years.
- Compounded medications of which at least one ingredient is a covered drug.
- Prescription Drug for Abortion. Mifepristone is covered when provided under the Food and Drug Administration (FDA) approved treatment regimen.

Preventive Care (Refer to Appendices for specific benefit levels, based on the CHP in which you are enrolled)

The wellness/preventive services payable by this *plan* are designed to comply with Health Reform regulations and the current recommendations of the United States Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA), and the Centers for Disease Control and Prevention (CDC). This website lists the types of payable preventive services: http://www.healthcare.gov/law/about/provisions/services/lists.html.

Professional Services

1. Services of a *physician*.
2. Services of an anesthetist (M.D. or C.R.N.A.).

Prosthetic Devices

1. Breast prostheses following a mastectomy.
2. *Prosthetic devices* to restore a method of speaking when required as a result of a covered *medically necessary* laryngectomy.
3. The *plan* will pay for other *medically necessary prosthetic devices,* including:
   a. Surgical implants, including implantable hearing devices;
   b. Artificial limbs or eyes; and
   c. The first pair of contact lenses or eye glasses when required as a result of a covered *medically necessary* eye surgery.

Reconstructive Surgery

Reconstructive surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomatology or creating a normal appearance.

Radiation Therapy

Treatment by use of x-ray, radium cobalt and radioactive isotopes to destroy cancer cells. Radiation therapy will usually follow surgical treatment and may be used in combination with other cancer treatments. To minimize the damage to healthy tissue and maximize the delivery of radiation to the tumor, simulation of the radiation treatment is carried out on computer-generated "phantoms". CAT scans are used to help target and anatomically visualize the tumor.

Radiation Therapy Services are performed most commonly in Outpatient setting but can be administered inpatient.

Screening For Blood Lead Levels

Services and supplies provided in connection with screening for blood lead levels if your dependent *child* is at risk for lead poisoning, as determined by your *physician,* when the screening is prescribed by your *physician*.

Skilled Nursing Facility

Inpatient services and supplies provided by a *skilled nursing facility for a* **maximum of 100 days per *plan year*.** The amount by which your room charge exceeds the prevailing two-bed room rate of the *skilled nursing facility* is not considered *covered expense*.

Skilled nursing facility services and supplies are subject to prior authorization to determine medical necessity. Please refer to MEDICAL MANAGEMENT PROGRAMS: AUTHORIZATION PROGRAM for information on how to obtain the proper reviews.

Speech Therapy

Outpatient charges of a qualified speech therapist for correction of a speech impediment incurred if caused by sickness or injury or due to surgery because of illness. Lifetime maximum benefit is $1,000 per covered person.

Substance Abuse (Refer to Appendices for specific benefit levels, based on the CHP in which you are enrolled)

Covered services shown below for the treatment of substance abuse, provided such services offer a reasonable expectation of improvement, and are the lowest level of care consistent with safe medical practice.

1. Inpatient *hospital* services as stated in the "Hospital" provision of this section.
2. Visits to a *day treatment center*.

   All inpatient services, including day treatment care, are subject to prior authorization to determine medical necessity. Please refer to MEDICAL MANAGEMENT PROGRAMS for information on how to obtain the proper

reviews.

3. *Physician* visits during a covered inpatient *stay.*

4. *Physician* visits for outpatient treatment of substance abuse. *Physician* visits for rehabilitative care (such as physical therapy).

Treatment for substance abuse does not include smoking cessation programs, or treatment for nicotine dependency or tobacco use.

Surgery

Surgery conducted at an inpatient hospital, outpatient hospital, outpatient surgery facility, ambulatory surgery center, or physician's office.

Sterilization

Expenses incurred for sterilization.

Urgent Care

Treatment received for a sudden, serious, or unexpected illness, injury or condition at an urgent care clinic or facility.

MEDICAL CARE THAT IS NOT COVERED

No payment will be made under this *plan* for expenses incurred for or in connection with any of the items below. (The titles given to these exclusions and limitations are for ease of reference only; they are not meant to be an integral part of the exclusions and limitations and do not modify their meaning.)

Chronic Pain. Treatment of chronic pain, except as specifically provided under the "Acupuncture" , "Hospice Care" or "Home Infusion Therapy" provisions of MEDICAL CARE THAT IS COVERED.

Clinical Trials. Services and supplies in connection with clinical trials, except as specifically stated in the "Cancer Clinical Trials" provision under the section MEDICAL CARE THAT IS COVERED.

***Cosmetic* Surgery or other Treatment.** Services and supplies in connection with *cosmetic* surgery or other treatment. This exclusion does not apply to reconstructive surgery (that is, surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomatology or to create a normal appearance), including surgery performed to restore symmetry following mastectomy. *Cosmetic* surgery does not become reconstructive surgery because of psychological or psychiatric reasons.

Crime. Conditions that result from your commission of or attempt to commit a felony unless such injury or illness is the direct result of domestic violence or your commission of or attempt to commit a felony is the direct result of an underlying health factor.

Custodial Care or Rest Cures. Inpatient room and board charges in connection with a *hospital stay* primarily for environmental change or physical therapy. *Custodial care* or rest cures, except as specifically provided under the "Hospice Care" or "Home Infusion Therapy" provisions of MEDICAL CARE THAT IS COVERED. Services provided by a rest home, a home for the aged, a nursing home or any similar facility. Services provided by a *skilled nursing facility,* except as specifically stated in the "Skilled Nursing Facility" provision of MEDICAL CARE THAT IS COVERED.

Dental Services or Supplies. Dental plates, bridges, crowns, caps or other dental prostheses, dental services, extraction of teeth, or treatment to the teeth or gums, or treatment to or for any disorders for the jaw joint, except as specifically stated in the "Dental Care" provision of MEDICAL CARE THAT IS COVERED. Cosmetic dental surgery or other dental services for beautification.

Education or Counseling. Educational services, or nutritional counseling, except as specifically provided or arranged by the *claims administrator*, or as stated under the "Home Infusion Therapy" provision of MEDICAL CARE THAT IS COVERED.

Exercise Equipment. Exercise equipment, or any charges for activities, instrumentalities, or facilities normally intended or used for developing or maintaining physical fitness, including, but not limited to, charges from a physical fitness instructor, health club or gym, even if ordered by a *physician*.

Excess Amounts. Any amounts in excess of *covered expense* or any applicable benefit maximum.

Experimental or Investigative. Any *experimental* or *investigational* procedure or medication. However, if you have a life-threatening or seriously debilitating condition and the *claims administrator* determines that requested treatment is not a covered service because it is *experimental* or *investigational*, you may request an independent medical review. (See COMPLAINT NOTICE)

Eye Surgery for Refractive Defects. Any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) and/or astigmatism. Contact lenses and eyeglasses required as a result of this surgery.

Food Supplements. Food or dietary supplements, except as specifically stated under the "Special Food Products" provision of MEDICAL CARE THAT IS COVERED.

Gastric Bypass Surgery. Services and supplies for gastric bypass surgery, unless *medically necessary*.

Government Treatment. Any services actually given to you by a local, state or federal government agency, except when payment under this *plan* is expressly required by federal or state law. The *plan* will not cover payment for these services if you are not required to pay for them or they are given to you for free.

Home or Vehicle Modification. Expenses for construction or modification to a home, residence or vehicle required as a result of an injury, illness or disability, including, without limitation, construction or modification of ramps, elevators, hand rails, chair lifts, spas/hot tubs, air conditioning, dehumidification devices, asbestos removal, air filtration/purification, swimming pools, emergency alert system, etc.

Hypnotherapy. Therapy based on or using hypnosis.

Infertility Treatment. Any services or supplies furnished in connection with the treatment of infertility, including, but not limited to, medication, surgery, artificial insemination, in vitro fertilization, sterilization reversal, and gamete intrafallopian transfer.

Inpatient Diagnostic Tests. Inpatient room and board charges in connection with a *hospital stay* primarily for diagnostic tests that could have been performed safely on an outpatient basis.

Lifestyle Programs. Programs to alter one's lifestyle that may include but are not limited to diet, exercise, imagery or nutrition.

Mental or Nervous Disorders. Academic or educational testing, counseling, and remediation. *Mental or nervous disorders* or substance abuse, including rehabilitative care in relation to these conditions, except as specifically stated in the "Mental Health" or "Substance Abuse" provisions of MEDICAL CARE THAT IS COVERED.

Nicotine Use. Smoking cessation programs or treatment of nicotine or tobacco use. Smoking cessation drugs.

Not Covered. Services received before your *effective date* or after your coverage ends, except as specifically stated under EXTENSION OF BENEFITS.

Not Medically Necessary. Services or supplies that are not *medically necessary,* as defined.

Not Specifically Listed. Services not specifically listed in this *plan* as covered services.

Nuclear Energy. Services or supplies to treat a condition caused by any release of nuclear energy, whether or not the result of war, when government funds are available for treatment of illness or injury arising from such release of nuclear energy.

Orthodontia. Braces and other orthodontic appliances or services.

Optometric Services or Supplies. Optometric services, eye exercises including orthoptics. Routine eye exams and routine eye refractions, except routine eye screenings provided as part of routine physical examinations under "Well

Baby and Well Child Care" or "Preventive Care" benefits of MEDICAL CARE THAT IS COVERED. Eyeglasses or contact lenses, except as specifically stated in the "Prosthetic Devices" provision of MEDICAL CARE THAT IS COVERED.

Orthopedic Supplies. Orthopedic shoes (other than shoes joined to braces) or non-custom molded and cast shoe inserts.

Outpatient Occupational Therapy. Outpatient occupational therapy, except by a *home health agency, hospice* or *home infusion therapy provider* as specifically stated in the "Home Health Care", "Hospice Care", "Home Infusion Therapy" provisions of MEDICAL CARE THAT IS COVERED.

Outpatient Speech Therapy. Outpatient speech therapy except as stated in the "Outpatient Speech Therapy" provision of MEDICAL CARE THAT IS COVERED.

Personal Items. Any supplies for comfort, hygiene or beautification.

Prescription Drug[1]

- Anti-obesity medications
- Anti-wrinkle agents
- Injectable, implants and intra-uterine contraceptive devices[1]
- Cosmetic hair removal products
- Growth Hormones
- Hair growth stimulants
- Immunization agents, blood or blood plasma
- Infertility medications
- Therapeutic devices or appliances unless listed as a covered product
- Charges for the administration or injection of any drug
- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals. This exclusion does not apply to patients in a Long Term Care facility which dispense/require single dose drug packaging.

Private Contracts. Services or supplies provided pursuant to a private contract between the *beneficiary* and a provider, for which reimbursement under the Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.

Relatives' Services. Professional services received from a person who lives in your home or who is related to you by blood or marriage, except as specifically stated in the "Home Infusion Therapy" provision of MEDICAL CARE THAT IS COVERED.

Scalp hair prostheses. Scalp hair prostheses, including wigs or any form of hair replacement.

Sex Transformation. Procedures or treatments to change characteristics of the body to those of the opposite sex.

Sterilization Reversal. Reversal of sterilization.**War or Similar Event.** Expenses incurred as a result of an injury or illness due to any act of war, either declared or undeclared, war-like act, riot, insurrection, rebellion, or invasion, except as required by law.

Weight Alteration Programs (Inpatient and Outpatient). Weight loss or weight gain programs including, but not limited to, dietary evaluations and counseling, exercise programs, behavioral modification programs, surgery, laboratory tests, food and food supplements, vitamins and other nutritional supplements associated with weight loss or weight gain, unless it is for the treatment of anorexia nervosa or bulimia nervosa. Treatment for morbid obesity is covered only when specific criteria are met as recommended by the *claims administrator's* Medical Policy.

[1] Contraceptive devices are not covered as part of CVS/Caremark's prescription drug program, but are covered under the medical benefit through Anthem Blue Cross Life and Health. Oral contraceptives are a covered prescription drug benefit through CVS/Caremark.

Work-Related. Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, even if you do not claim those benefits.

Voluntary Payment. Services for which you are not legally obligated to pay. Services for which you are not charged. Services for which no charge is made in the absence of insurance coverage, except services received at a non-governmental charitable research *hospital*. Such a *hospital* must meet the following guidelines:

1. It must be internationally known as being devoted mainly to medical research;
2. At least **10%** of its yearly budget must be spent on research not directly related to patient care;
3. At least one-third of its gross income must come from donations or grants other than gifts or payments for patient care;
4. It must accept patients who are unable to pay; and
5. Two-thirds of its patients must have conditions directly related to the hospital's research.

ELIGIBILITY - HOW COVERAGE BEGINS

ELIGIBLE STATUS

1. **Employees.** You are in an eligible status if you are a County of Sonoma *full-time permanent employee* or a *part-time permanent employee and meet the eligibility requirements as defined in your applicable Memorandum of Understanding*.
2. **Dependents.** The following are eligible to enroll as *dependents* **(see below for definitions)**:
   (a) Either the *subscriber's spouse* or *domestic partner;*
   (b) A *child* under age 26;
   (c) An unmarried dependent *child* age 26 or older who is permanently disabled, provided the disability existed prior to reaching age 26
3. **Retirees.** If you are a *retired employee*, you are eligible if you:
   (a) Were eligible as an active employee before retirement; and
   (b) Are receiving retirement benefits from the Sonoma County's Employees Retirement Association (SCERA); and
   (c) Have been continuously covered under a County offered medical plan prior to retirement; and
   (d) Meet the specific eligibility requirements of the Memorandum of Understanding or Salary Resolution, which you were retired under as an active employee, or
   (e) Meet the eligibility requirements of an affiliated County agency.
   (f) If you or any of your eligible dependents turn age 65 and become Medicare eligible, it is required that you enroll in Medicare Parts A and B. In order to complete the enrollment process, retirees or any eligible dependents that turn age 65, must provide a copy of their Medicare card and complete new health enrollment forms. Proof of Medicare eligibility is required to maintain eligibility for coverage under this *plan*. Failure to enroll timely into Medicare and provide proof will result in termination of your health coverage.

Definition of Dependent

1. **Spouse** is the *subscriber's* spouse under a legally valid marriage between persons of the opposite sex.
2. **Domestic partner** is the *subscriber*'s domestic partner as attested to by registration or legal marriage (same sex couple only) with the state of residence or the *subscriber* signing a domestic partnership affidavit and filing it with the County.

3. **Child** is the *subscriber*'s, *spouse*'s or *domestic partner's* natural child, stepchild, legally adopted child, foster child, or a child for whom the *subscriber, spouse* or *domestic partner* has been appointed legal guardian by a court of law, subject to the following:

   a. A child through the end of the month they turn age 26.

   b. A child who is in the process of being adopted is considered a legally adopted child if we receive legal evidence of both: (i) the intent to adopt; and (ii) that the *subscriber, spouse* or *domestic partner* have either: (a) the right to control the health care of the child; or (b) assumed a legal obligation for full or partial financial responsibility for the child in anticipation of the child's adoption.

      Legal evidence to control the health care of the child means a written document, including, but not limited to, a health facility minor release report, a medical authorization form, or relinquishment form, signed by the child's birth parent, or other appropriate authority, or in the absence of a written document, other evidence of the *employee*'s, the *spouse*'s or *domestic partner's* right to control the health care of the child.

   c. A child for whom the *subscriber, spouse* or *domestic partner* is a legal guardian is considered eligible on the date of the court decree (the "eligibility date"). We must receive legal evidence of the decree.

   d. The term "child" does not include any person who is: (i) covered as an *employee*; or (ii) in active service in the armed forces.

ELIGIBILITY DATE

1. For *employees,* you become eligible for coverage on the first day of the month following employment. (This is your "waiting" period.)

2. For *retirees,* you become eligible for coverage on the first day of the month following or coinciding with retirement.

3. For *dependents,* you become eligible for coverage on the later of: (a) the date the *employee* becomes eligible for coverage; or, (b) the first of the month following the date you meet the *dependent* definition.

ENROLLMENT

To enroll as subscriber, or to enroll *dependents,* the *employee or retiree* must enroll by completing the necessary forms. The enrollment forms and any requested proof of dependency status such as marriage license or birth certificate must be provided to the *plan administrator* within 31 days from your eligibility date. If any of these steps are not followed, your coverage may be denied.

COORDINATION OF BENEFITS WITH MEDICARE

To comply with federal Medicare coordination of benefit regulations, you must promptly furnish to the Plan Administrator, or its designee, the Social Security Number (SSN) of your Eligible Dependents for which you have elected, or are electing, Plan coverage, and information on whether you or any of such dependents are currently enrolled in Medicare or have disenrolled from Medicare. This information will be requested when you first enroll for Plan coverage but may also be requested at a later date.

Failure to provide the SSN or complete the CMS model form (form is available from the Claims Administrator or https://www.cms.gov/MandatoryInsRep/Downloads/RevisedHICNSSNForm081809.pdf) means that claims for eligible individuals cannot be processed for the affected individuals.

EFFECTIVE DATE

Your effective date of coverage is subject to the timely payment of required contributions. The date you become covered is determined as follows:

Timely Enrollment: If you enroll for coverage before, on, or within 31 days after your eligibility date, then your coverage will begin as follows: (a) for *subscribers*, on your eligibility date; and (b) for *dependents*, on the later of (i) the date the *subscriber* coverage begins, or (ii) the first day of the month after the *dependent* becomes eligible. If you become eligible before the *plan* takes effect, coverage begins on the effective date of the *plan*, provided the enrollment application is on time and in order.

Late Enrollment: If you enroll more than 31 days after your eligibility date, you must wait until the next Annual Enrollment Period to enroll unless you qualify for a Special Mid-Year Enrollment in which case the effective date shall be the first of the month following or coinciding with the event.

You may enroll or drop coverage earlier than the next Annual Enrollment period only under a limited number of circumstances as described in the Employee Health and Welfare benefits booklet under "When Changes are Allowed". For retirees this is described in the Salary Resolution and Retiree Health and Welfare Benefits Booklet.

SPECIAL ENROLLMENT PERIODS

Any change you make as a result of a qualified change in status must be permitted by law, County policy, and be consistent with the qualifying event. Benefit changes are consistent with the event only if they (1) result in you, your *spouse* or *domestic partner* or your *dependent* gaining or losing eligibility to participate in this *plan* or the plan of your spouse's or domestic partner's or your dependent's employer and (2) correspond with the gain or loss of coverage.

You must notify the County of the qualified change in status within 31 days of the event. The subscribing member is responsible to notify the County when their *dependents* no longer meet the eligibility requirements. Without this notification, premiums will continue to be deducted from your paycheck, and you may be personally responsible for medical expenses incurred during the time your *dependent* was ineligible, as defined above.

ANNUAL ENROLLMENT PERIOD

There is an annual enrollment period once each *plan year* in the spring. During that time, an individual who meets the eligibility requirements as an employee under this *plan* may enroll. An employee may also enroll any eligible dependents at that time. Persons eligible to enroll as dependents may enroll only under the employee's plan.

Retiree's enrolled in a different County sponsored medical plan may enroll in this *plan* during Annual Enrollment. However, dependent enrollment is more limited than it is for employees. Refer to your Annual Enrollment booklet or Health and Welfare booklet for complete details.

For anyone so enrolling, coverage under this *plan* will begin June 1st. Coverage under the former plan ends when coverage under this *plan* begins.

HOW COVERAGE ENDS

Your coverage ends as provided below:

1. If the *plan* terminates, your coverage ends at the same time.
2. Coverage for dependents ends when *subscriber's* coverage ends.
3. Coverage ends if any required premium is not timely paid.
4. Coverage ends the last day of the month following the date of separation from the County of Sonoma.
5. If you voluntarily cancel coverage at any time, coverage ends as follows:
    a. For *a subscriber,* coverage ends on the last day of the month following notice of voluntary cancellation, as provided by written notice to us;

b. For a *dependent* whose coverage is cancelled while the *subscriber's* coverage remains in effect, coverage ends on the last day of the month following the date of voluntary cancellation, as provided by written notice to us.

6. If you no longer meet the requirements set forth in the "Eligible Status" provision of HOW COVERAGE BEGINS, coverage ends as follows:

   a. For a *subscriber*, coverage ends on the last day of the month after or coinciding with the date the *subscriber* ceases to meet such requirements;

   b. For a *dependent* whose coverage is cancelled while the *subscriber's* coverage remains in effect, coverage ends on the last day of the month after or coinciding with the date the *dependent* ceases to meet such requirements.

Exceptions to item 6:

a. **Leave of Absence.** If you are an *employee* and the required contributions are paid, your coverage (including any dependent coverage) may continue for up to six months during an approved temporary unpaid leave of absence pursuant to the County's Leave of Absence Policy.

b. **Disabled Children:** If a *child* reaches the age limits shown in the "Eligible Status" provision of this section, the *child* will continue to qualify as a dependent if he or she is (i) covered under this *plan,* (ii) is unmarried, (iii) still financially dependent on the *subscriber*, *spouse* or *domestic partner for more than half of his or her support,* and (iv) incapable of self- sustaining employment due to a physical or mental disability. A *physician* must certify this disability in writing. We must receive the certification within 31 days of the date the *child* otherwise becomes ineligible. When a period of one year has passed, we may request proof of continuing dependency and disability, but not more often than once each year. This exception will last until the *child* is no longer disabled or dependent on the *subscriber*, *spouse* or *domestic partner* for financial support. A *child* is considered financially dependent if he or she qualifies as a dependent for federal income tax purposes.

Note: If a marriage or domestic partnership terminates, the *subscriber* must give or send to the *plan administrator* written notice of the termination. Coverage for a former *spouse* or *domestic partner*, and their dependent *children*, if any, ends according to the "Eligible Status" provisions. If the *subscriber* notifies the *plan administrator* in writing to cancel coverage for a former *spouse* or *domestic partner* and the *children* of the *spouse* or *domestic partner*, if any, immediately upon termination of the *subscriber's* marriage or domestic partnership, such notice will be considered compliance with the requirements of this provision.

RIGHT TO CERTIFICATE OF CREDITABLE COVERAGE

When your coverage under this *plan* ends, the *plan* is required to provide a written certification of how long your coverage was in effect. The purpose of this "Certificate of Creditable Coverage" is to help you obtain coverage under another plan.

You will automatically be sent a Certificate of Creditable Coverage at the time your coverage ends and again when continuation of coverage under COBRA (if elected) ends. You also may request a Certificate of Creditable Coverage from the *plan administrator* at any time within the 24-month period after your *plan* coverage ends.

You should contact the plan administrator for your new coverage if a preexisting condition limitation applies and if certification of prior coverage is needed. If your new health insurance is obtained through a plan other than an employer-sponsored group health plan, contact your state's insurance department for more information.

CONTINUATION OF COVERAGE

You may be able to continue coverage under this *plan* under certain conditions.

Leave of Absence. If you take a leave of absence without pay during the time which your eligibility would normally terminate, you may continue your coverage by making the required payments for the cost of *plan* benefits for yourself and your eligible dependent(s). Benefit coverage may be continued in this manner only for such a term that is

consistent with the *plan administrator's* Leave of Absence policy.

Disability. If you file a disability retirement application prior to termination of coverage under this *plan*, you may elect to continue coverage for yourself or your eligible dependent(s) by making the required payments for the cost of coverage until such time as the SCERA announces its decision on your disability retirement application. You may be reimbursed for payments made for coverage after the effective date of your retirement.

If you wish to continue coverage under either of the circumstances above (unpaid leave or disability) you must make the required payments to the *plan administrator* or designee prior to the month for which coverage is requested and in accordance with the schedule provided by the *plan administrator* or designee. If you fail to make a timely payment, you cannot resume self-payments at a later time.

COBRA Continuation

Under a federal law commonly known as Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, you, your *spouse* or domestic partner, and dependent children may elect to temporarily continue coverage under this *plan* in certain instances where coverage otherwise would be reduced or terminated. Individuals entitled to COBRA continuation (qualified beneficiaries) are you, your *spouse* or *domestic partner* and your dependent children who are covered at the time of a qualifying event. In addition, a child who is born to you or adopted or placed for adoption with you during the COBRA coverage period is also a qualified beneficiary.

The table below provides a summary of the COBRA provisions outlined in this section.

Qualifying Events that Result in Loss of Coverage	**Maximum Continuation Period**		
	Employee	*Spouse* or domestic partner	Child
Employee's work hours are reduced and results in loss of coverage	18 months	18 months	18 months
Employee terminates employment for any reason (other than gross misconduct)	18 months	18 months	18 months
Employee becomes entitled to Medicare as a retiree	N/A	36 months	36 months
Employee or dependent is disabled (as determined by the Social Security Administration) at the time of the qualifying event or becomes disabled within the first 60 days of COBRA continuation that begins as a result of termination or reduction in work hours	29 months	29 months	29 months
Employee dies	N/A	36 months	36 months
Employee and *spouse* legally separate or divorce or a termination of a domestic partnership is filed	N/A	36 months	36 months

Qualifying Events that Result in Loss of Coverage	**Maximum Continuation Period**		
	Employee	*Spouse* or domestic partner	Child

Employee becomes entitled to Medicare within 18 months prior to termination of employment or reduction in work hours	N/A	36 months*	36 months*
Child no longer qualifies as a dependent	N/A	N/A	36 months

* 36-month period is counted from the date you become entitled to Medicare.

Qualifying Events

If your employment terminates for any reason other than your gross misconduct or if your hours worked are reduced so that your *plan* coverage terminates, you, your covered *spouse* or domestic partner and dependent children may continue health coverage under the *plan* for up to 18 months.

If you (the *subscriber*) should die, become legally separated or divorced or become entitled to Medicare, your covered dependents whose health coverage under the *plan* would be reduced or terminated may continue health coverage under the *plan* for up to 36 months. Also, your covered children may continue health coverage for up to 36 months after they no longer qualify as covered dependents under the terms of the *plan.*

Certain events may extend an 18-month COBRA continuation period applicable to your termination of employment or reduction in hours worked:

- If your dependent(s) experience a second qualifying event within the original 18-month period, they (but not you) may extend the COBRA continuation period for up to an additional 18 months (for a total of up to 36 months from the original qualifying event).
- If you (the employee) became entitled to Medicare while employed (even if it was not a qualifying event for your covered dependents because their coverage was not lost or reduced) and then a second qualifying event (i.e., your termination of employment or reduction in hours of work) happens within 18 months, your dependents may elect COBRA continuation for up to 36 months from the date you became entitled to Medicare.
- If you or your dependent is disabled (as determined by the Social Security Administration) on the date of a termination of employment or reduction in work hours or at any time during the first 60 days of COBRA continuation coverage due to such event, each qualified beneficiary (whether or not disabled) may extend COBRA continuation coverage for up to an additional 11 months (for a total of up to 29 months). To qualify for this disability extension, the *plan administrator* must be notified of the person's disability status both within 60 days after the Social Security disability determination is issued *and* before the end of the original 18-month COBRA continuation period. Also, if Social Security determines that the qualified beneficiary is no longer disabled, you are required to notify the *plan administrator* within 30 days after this determination.

Important Note: If a second qualifying event occurs at any time during this 29-month disability continuation period, then each qualified beneficiary who is a *spouse* or domestic partner or dependent child (whether or not disabled) may further extend COBRA coverage for seven more months, for a total of up to 36 months from the termination of employment or reduction in hours of employment.

Continuation of Coverage under California Law after COBRA Coverage Is Exhausted

Note: This section pertains only to members whose federal COBRA coverage started on or after January 1, 2003.
If you live in California, you have the option to continue your medical coverage for up to 36 months from the date your COBRA coverage originally began, provided:

- You exhaust the 18- or 29-month COBRA period available to you under federal law
- You agree to pay premiums up to 110% of the cost of the plan (up to 150%, if you are disabled pursuant to Title II or Title XVI of the Social Security Act).
- You elect to extend medical coverage within 60 days following the later of:
    - The date the initial COBRA coverage period would end under federal law, or

- The date *plan administrator* informs you of your rights under this section.

- Within 45 days of your election to extend medical coverage, you send *plan administrator* the first premium payment in full.

This extended medical coverage will end on the earliest of the following:

- The date that is 36 months after your original COBRA continuation period began.
- The date the group contract discontinues in its entirety. (However, continuation coverage may be available to you under another insured company-sponsored medical plan.)
- The end of the period for which you made premium payments, if you cease to make any required contributions or fail to make timely required contributions.
- The day after you are or become covered under another group health plan. (However, continued coverage will not terminate until you are no longer affected by a preexisting condition exclusion or limitation under the other group health plan.)
- The date you are or become entitled to benefits under Medicare. (This will not apply if contrary to the provisions of the Medicare Secondary Payer Rules or other federal law.)
- The date the County no longer provides insured group medical plan coverage to any of its employees.
- The date you move out of the insurer's service area.
- The date you commit fraud or deception in the use of benefits
- The month that begins more than 31 days after the date of the final determination that you are no longer disabled under Title II or Title XVI of the Social Security Act.

If you have any questions about this notice, or require further information about you rights, you should contact CONEXIS at 877-529-9323.

Giving Notice That a COBRA Event Has Occurred

To qualify for COBRA continuation upon legal separation, divorce or loss of child's dependent status under the *plan*, you or one of your dependents MUST notify the *plan administrator* of the legal separation, divorce or loss of dependent status within 60 days of the later of the date of the event or the date the individual would lose coverage under the *plan*. Your covered dependents then will be provided with instructions for continuing your health coverage. Individuals already on COBRA continuation must notify the *plan administrator* within these deadlines if a legal separation, divorce or loss of a child's dependent status occurs that would extend the period of COBRA coverage for your *spouse*, *domestic partner*, or *dependent* child(ren).
For other qualifying events (if your employment ends, your hours are reduced, or you become entitled to Medicare), you and your covered dependents will be provided with instructions for continuing your health coverage.

Electing and Paying for COBRA Continuation Coverage

You and/or your covered dependents must choose to continue coverage within 60 days after the later of the following dates:

- The date you and/or your covered dependents(s) would lose coverage as a result of the qualifying event
- The date the *plan administrator* notifies you and/or your covered dependents of your right to choose to continue coverage as a result of the qualifying event.

Premium Due Date: If you elect COBRA continuation coverage, you must pay the initial premium (including all premiums due but not paid) within 45 days after your election. Thereafter, COBRA premiums must be paid monthly and within 30 days of each due date. If you elect COBRA continuation but then fail to pay the premium due within the initial 45-day grace period, or you fail to pay any subsequent premium within 30 days after the date it is due, your coverage will be terminated retroactively to the last day for which timely payment was made.

Cost of Continuing Active Coverage: The cost of COBRA coverage is 102% of the full cost of plan coverage.

Additional Cost Requirements for Continuation of Active Coverage Only: The cost of coverage for the 19th through 29th months of coverage under the disability extension is (1) 150% of the full cost of coverage for all family members participating in the same coverage option as the disabled individual, and (2) 102% for any family members participating in a different coverage option than the disabled individual, except as provided below.

If a second qualifying event occurs during the first 18 months of coverage, the 102% rate applies to the full 36 months even if the individual is disabled. However, if a second qualifying event occurs during the otherwise applicable disability extension period (that is, during the 19th through 29th month), then the rate for the 19th through 36th months of the COBRA continuation period is (1) the 150% rate for all family members participating in the same coverage option as the disabled individual, and (2) the 102% rate for any family members in a different coverage option than the disabled individual.

Coverage During the Continuation Period

If coverage under the *plan* is changed for active employees, the same changes will be provided to individuals on COBRA continuation. Qualified beneficiaries also may change their coverage elections during the annual enrollment periods, if a change in status occurs, or at other times under the *plan* to the same extent that similarly situated individuals for whom a qualify event has not occurred may do so.

When COBRA Continuation Coverage Ends

COBRA continuation of health coverage for any person will end when the first of the following occurs:

- The applicable continuation period ends.
- The initial premium for continued coverage is not paid within 45 days after the date COBRA is elected, or any subsequent premium is not paid within 30 days after it is due.
- After the date COBRA is elected, the qualified beneficiary first becomes covered (as an employee or otherwise) under another group health plan not offered by the County that does not contain an exclusion or limitation affecting the person's preexisting condition, or the other plan's preexisting condition limit or exclusion does not apply or is satisfied because of the HIPAA rules.
- After the date COBRA is elected, the qualified beneficiary first becomes entitled to Medicare. (This does not apply to other qualified beneficiaries who are not entitled to Medicare.)
- In the case of the extended coverage period due to a disability, there has been a final determination, under the Social Security Act, that the qualified beneficiary is no longer disabled. In such a case, the COBRA coverage ceases on the first day of the month that begins more than 30 days after the final determination is issued, unless a second qualifying event has occurred during the first 18 months.
- For newborns and children adopted by or placed for adoption with you (the employee) during your COBRA continuation period, the date your COBRA continuation period ends unless a second qualifying event has occurred.

When your COBRA continuation coverage ends, you will receive a Certificate of Creditable Coverage. Refer to page 23 for details.

Continuation of Coverage for Employees in the Uniformed Services

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) guarantees certain rights to eligible employees who enter military service. Upon reinstatement, you are entitled to the seniority, rights and benefits associated with the position held at the time employment was interrupted, plus additional seniority, rights and benefits that would have been attained if employment had not been interrupted.

If your military leave is for less than 31 days, you may continue your medical coverage by paying the same amount charged to active employees for the same coverage. If your leave is for a longer period of time, you will be charged up to the full cost of coverage plus a 2% administrative fee.

The maximum period of continuation coverage available to you and your eligible dependents is the lesser of 24 months after the leave begins or the day the leave ends.

When you go on military leave, your work hours are reduced. As a result, you and your covered dependents may become eligible for COBRA. Any COBRA continuation period for which you are eligible will run concurrently with any USERRA continuation period for which you are eligible.

If you choose not to continue your medical coverage while on military leave, you are entitled to reinstated health coverage with no waiting periods or exclusions (however, an exception applies to service-related disabilities) when you return from leave.

In general, to be eligible for the rights guaranteed by USERRA, you must:

- Return to work on the first full, regularly scheduled workday following your leave, safe transport home, and an eight-hour rest period if you are on a military leave of less than 31 days
- Return to or reapply for reemployment within 14 days of completion of such period of duty, if your absence from employment is from 31 to 180 days
- Return to or reapply for reemployment within 90 days of completion of your period of duty, if your military service lasts more than 180 days.

Continuation of Coverage While on a Family and Medical Leave

Under the federal Family and Medical Leave Act (FMLA), employees are generally allowed to take up to 12 weeks of unpaid leave for certain family and medical situations and continue their elected medical coverage benefits during this time.

If you are eligible, you can take up to 12 weeks of unpaid leave in a 12-month period for the following reasons:

- For the birth and care of your newborn child or a child that is placed with you for adoption or foster care
- To care for a *spouse*, child, or parent who has a serious health condition
- For your own serious health condition.

Depending on the state you live in, the number of weeks of unpaid leave available to you for family and medical reasons may vary based on state law requirements.

REIMBURSEMENT FOR ACTS OF THIRD PARTIES

Under some circumstances, a *beneficiary* may need services under this *plan* for which a third party may be liable or legally responsible by reason of negligence, an intentional act or breach of any legal obligation. In that event, we will provide the benefits of this *plan* subject to the following:

1. We will automatically have a lien, to the extent of benefits provided, upon any recovery, whether by settlement, judgment or otherwise, that you receive from the third party, the third party's insurer, or the third party's guarantor. The lien will be in the amount of benefits we paid under this *plan* for the treatment of the illness, disease, injury or condition for which the third party is liable.
    - Our lien will not be more than the amount we paid for those services.
    - If you hired an attorney to gain your recovery from the third party, our lien will not be for more than one-third of the money due you under any final judgment, compromise, or settlement agreement.
    - If you did not hire an attorney, our lien will not be for more than one-half of the money due you under any final judgment, compromise or settlement agreement.
    - If a final judgment includes a special finding by a judge, jury, or arbitrator that you were partially at fault, our lien will be reduced by the same comparative fault percentage by which your recovery was reduced.
    - Our lien is subject to a pro rata reduction equal to your reasonable attorney’s fees and costs in line with the common fund doctrine.
2. You must advise us in writing, within 60 days of filing a claim against the third party and take necessary action, furnish such information and assistance, and execute such papers as we may require to facilitate

enforcement of our rights. You must not take action, which may prejudice our rights or interests under your *plan*. Failure to give us such notice or to cooperate with us, or actions that prejudice our rights or interests will be a material breach of this *plan* and will result in your being personally responsible for reimbursing us.

3. We will be entitled to collect on our lien even if the amount you or anyone recovered for you (or your estate, parent or legal guardian) from or for the account of such third party as compensation for the injury, illness or condition is less than the actual loss you suffered.

COORDINATION OF BENEFITS

If you are covered by more than one group medical plan, your benefits under this Plan will be coordinated with the benefits of those Other Plans, as shown below. These coordination provisions apply separately to each *beneficiary,* per *benefit year*. Any coverage you have for medical benefits will be coordinated as shown below.

Definitions for Coordination of Benefits Section

The meanings of key terms used in this section are shown below. Whenever any of the key terms shown below appear in these provisions, the first letter of each word will be capitalized. When you see these capitalized words, you should refer to this “Definitions” provision.

Allowable Expense is any necessary, reasonable and customary item of expense, which is at least partially covered by at least one Other Plan. For the purposes of determining our payment, the total value of Allowable Expense as provided under this *plan* and all Other Plans will not exceed the amount, which *this plan* would pay, if you were covered under this *plan* only.

Other Plan is any of the following:

1. Group, blanket or franchise insurance coverage;
2. Group service plan contract, group practice, group individual practice and other group prepayment coverages;
3. Group coverage under labor-management trusteed plans, union benefit organization plans, employer organization plans, employee benefit organization plans or self-insured employee benefit plans.

The term "Other Plan" refers separately to each agreement, policy, contract, or other arrangement for services and benefits, and only to that portion of such agreement, policy, contract, or arrangement which reserves the right to take the services or benefits of other plans into consideration in determining benefits.

Primary Plan is the plan which will have its benefits determined first.

This Plan is that portion of this *plan* that provides benefits subject to this provision.

Effect On Benefits

1. If This Plan is the Primary Plan, then its benefits will be determined first without taking into account the benefits or services of any Other Plan.
2. If This Plan is not the Primary Plan, then its benefits may be reduced so that the benefits and services of all the plans do not exceed Allowable Expense.
3. The benefits of This Plan will never be greater than the sum of the benefits that would have been paid if you were covered under This Plan only.

Order Of Benefits Determination

The following rules determine the order in which benefits are payable:

1. A plan that has no Coordination of Benefits provision pays before a plan, which has a Coordination of Benefits provision.
2. A plan that covers you as an employee pays before a plan, which covers you as a dependent. But, if you are retired and entitled to Medicare, Medicare pays (a) after the plan, which covers you as a dependent of an active employee, but (b) before the plan, which covers you as a *retired employee*.

For example: You are covered as a *retired employee* under this *plan* and entitled to Medicare (Medicare would normally pay first). You are also covered as a dependent of an active employee under another plan (in which case Medicare would pay second). In this situation, the plan which covers you as a dependent will pay first and the plan which covers you as a *retired employee* would pay last.

3. For a dependent *child* covered under plans of two parents, the plan of the parent whose birthday falls earlier in the *benefit year* pays before the plan of the parent whose birthday falls later in the *benefit year*. But if one plan does not have a birthday rule provision, the provisions of that plan determine the order of benefits.

Exception to rule 3: For a dependent *child* of parents who are divorced or separated, the following rules will be used in place of Rule 3:

a. If the parent with custody of that *child* for whom a claim has been made has not remarried, then the plan of the parent with custody that covers that *child* as a dependent pays first.

b. If the parent with custody of that *child* for whom a claim has been made has remarried, then the order in which benefits are paid will be as follows:

   i. The plan that covers that *child* as a dependent of the parent with custody.

   ii. The plan that covers that *child* as a dependent of the stepparent (married to the parent with custody).

   iii. The plan that covers that *child* as a dependent of the parent without custody.

   iv. The plan that covers that *child* as a dependent of the stepparent (married to the parent without custody).

Regardless of a and b above, if there is a court decree which establishes a parent's financial responsibility for that *child's* health care coverage, a plan which covers that *child* as a dependent of that parent pays first.

4. The plan covering you as a laid-off or *retired employee* or as a dependent of a laid-off or *retired employee* pays after a plan covering you as other than a laid-off or *retired employee* or the dependent of such a person. But if either plan does not have a provision regarding laid-off or *retired employee*s, provision 6 applies.

5. The plan covering you under a continuation of coverage provision in accordance with state or federal law pays after a plan covering you as an employee, a dependent or otherwise, but not under a continuation of coverage provision in accordance with state or federal law. If the order of benefit determination provisions of the Other Plan does not agree under these circumstances with the Order of Benefit Determination provisions of This Plan, this rule will not apply.

6. When the above rules do not establish the order of payment, the plan on which you have been enrolled the longest pays first unless coverage under two of the plans became effective on the same date. In this case, Allowable Expense is split equally between the two plans.

Our Rights Under This Provision

Responsibility For Timely Notice. We are not responsible for coordination of benefits unless timely information has been provided by the requesting party regarding the application of this provision.

Reasonable Cash Value. If any Other Plan provides benefits in the form of services rather than cash payment, the reasonable cash value of services provided will be considered Allowable Expense. The reasonable cash value of such service will be considered a benefit paid, and our liability reduced accordingly.

Facility of Payment. If payments which should have been made under This Plan have been made under any Other Plan, we have the right to pay that Other Plan any amount we determine to be warranted to satisfy the intent of this provision. Any such amount will be considered a benefit paid under This Plan, and such payment will fully satisfy our liability under this provision.

Right of Recovery. If payments made under This Plan exceed the maximum payment necessary to satisfy the intent of this provision, we have the right to recover that excess amount from any persons or organizations to or for whom those payments were made, or from any insurance company or service plan.

BENEFITS FOR MEDICARE ELIGIBLE BENEFICIARIES

For Active Employees and Dependents. Any *beneficiary* who is a *full-time employee* or a *dependent* of a *full-time employee*, and eligible for Medicare, will receive the full benefits of this *plan*, except for the following:

1. *Beneficiaries* who are receiving treatment for end-stage renal disease following the first 30 months such *beneficiaries* are entitled to end-stage renal disease benefits under Medicare; and
2. *Beneficiaries* who are entitled to Medicare benefits as disabled persons; unless the *beneficiaries* have a current employment status, as determined by Medicare rules, through a group of 100 or more employees (according to OBRA legislation).

For cases where exceptions 1 or 2 apply, payment will be determined under the *plan* and the amount of benefits available from Medicare will be subtracted from such payment. The *plan* will pay the amount that remains after subtracting Medicare's payment.

For Retired Employees and Their *Spouses*. If you are a *retired employee* or the *spouse*, *domestic partner*, or *dependent* of a *retired employee* and you are eligible for Medicare, your benefits under this *plan* will be coordinated.

Medicare is the Primary Plan and this *plan* is the secondary plan. When you incur *covered expenses* under this *plan*, Medicare will make its payment first. Then, the *plan* will pay an amount, based on the type of covered expense (see examples below). Please note, the *plan* will not pay any benefit when Medicare's payment is equal to or more than the amount, which the *plan* would have paid in the absence of Medicare. The coordination of benefits method used is called Maintenance of Benefit. This *plan* may also not pay benefits where services are performed by a non-Medicare provider when Medicare providers are available and Medicare would have paid benefits equal to what the *plan* would have paid in the absence of Medicare.

Example of Medicare & CHP Coordination of a Co-Insurance benefit (Applicable to CHP-PPO members only). For an in-network *covered expense* of **$100**, and in the absence of Medicare, the *plan* would have paid **$90**. If Medicare pays **$80**, the *plan* would subtract that amount from the **$90** and pay **$10**. The combined amount of benefits from Medicare and this *plan* will equal, but not exceed, what your benefit would have been from this *plan* alone if you were not eligible for Medicare. For an out-of-network *covered expense* of **$100**, and in the absence of Medicare, the *plan* would have paid **$70**. If Medicare pays **$80**, the *plan* would subtract that amount from the **$70** and pay **$0**, because Medicare already paid more than the normal plan benefit.

Example of Medicare & CHP Coordination of a Co-Payment benefit. If you have a co-payment for an office visit, the chart below describes how your benefits will coordinate with Medicare.

Example #1 - Medical Provider Bill is more than $200	
$260	Charges submitted to Medicare as Primary payer
$228	$20 Member Co-pay + Medicare Payment of $208
$32	Balance Due - submitted to Anthem Blue Cross Life and Health to pay as secondary payer
Example #2 - Medical Provider Bill is equal to $200	
$200	Charges submitted to Medicare as Primary payer
$180	$20 Member Co-pay + Medicare Payment of $160
$20	Balance Due - submitted to Anthem Blue Cross Life and Health to pay as secondary payer
Example #3 - Medical Provider Bill is less than $200	
$6	Charges submitted to Medicare as Primary payer
0	$20 Member Co-pay + Medicare Payment of $48
$6	Overpayment - provider owes retiree $8

MEDICAL MANAGEMENT PROGRAMS

Benefits are provided only for *medically necessary* and appropriate services. Medical management programs including Utilization Review, Authorization, and Case Management are designed to work together with you and your provider to ensure you receive appropriate medical care and avoid unexpected out of pocket expense. The utilization review program applies to *hospital* admissions. The authorization program applies to certain specialized services or treatments. The personal case management program helps you coordinate and manage long-term intensive medical care.

No benefits are payable, however, unless your coverage is in force at the time services are rendered, and the payment of benefits is subject to all the terms and requirements of this *plan*.

Important: Medical management requirements described in this section do not apply when coverage under this *plan* is secondary to another plan providing benefits for you or your *dependents*.

UTILIZATION REVIEW PROGRAM

The utilization review program evaluates the medical necessity and appropriateness of care and the setting in which care is provided. You and your physician are advised if it has been determined that services can be safely provided in an outpatient setting, or if an inpatient stay is recommended. Services that are medically necessary and appropriate are certified by the claims administrator and monitored so that you know when it is no longer medically necessary and appropriate to continue those services. It is your responsibility to see that your *physician* starts the utilization review process before scheduling you for any service subject to the utilization review program. If you receive any such service, and do not follow the procedures set forth in this section, your benefits will be reduced as shown in the "Effect on Benefits" portion of **UTILIZATION REVIEW PROGRAM.**

Utilization Review Requirements

Utilization reviews are conducted for all inpatient *hospital stays.*

Exceptions: Utilization review is not required for the following services:

- Maternity care of 48 hours or less following a normal delivery or 96 hours or less following a cesarean section; and
- Mastectomy and lymph node dissection.

There are three stages of utilization review:

1. **Pre-service review** determines the medical necessity and appropriateness of scheduled, non-emergency *hospital* admissions.
2. **Concurrent review** determines whether services are *medically necessary* and appropriate when pre-service review is not required or the *claims administrator* is notified while service is ongoing, for example, an emergency admission to the hospital.
3. **Retrospective review** is performed to review services that have already been provided. This applies in cases when pre-authorization, pre-service or concurrent review was not completed, or in order to evaluate and audit medical documentation subsequent to services being provided. Retrospective review may also be performed for services that continued longer than originally certified.

Effect On Benefits

In order for the full benefits of this *plan* to be payable, the following criteria must be met:

1. The appropriate utilization reviews must be performed in accordance with this *plan*. When pre-service review is not performed as required for a *hospital* admission, in the absence of extraordinary circumstances*, no benefits will be provided.
2. The services must be *medically necessary* and appropriate. Inpatient *hospital* benefits will be provided only when an inpatient *stay* is *medically necessary* and appropriate. If you proceed with any services that have been determined to be not *medically necessary* and appropriate at any stage of the utilization review

process, benefits will not be provided for those services.

3. Services that are not reviewed prior to or during service delivery will be reviewed retrospectively when the bill is submitted for benefit payment. If that review results in the determination that part or all of the services were not *medically necessary* and appropriate*,* benefits will not be paid for those services. Remaining benefits will be subject to previously noted reductions that apply when the required reviews are not obtained.

***Extraordinary Circumstances.** In determining "extraordinary circumstances", the *claims administrator* may take into account whether or not your condition was severe enough to prevent you from notifying them, or whether or not a member of your family was available to notify the *claims administrator* for you. You may have to prove that such "extraordinary circumstances" were present at the time of the *emergency*.

How to Obtain Utilization Reviews

Remember, it is always your responsibility to confirm that the review has been performed.

Pre-service Reviews. Penalties will result for failure to obtain pre-service review, before receiving scheduled services, as follows:

1. For all scheduled services that are subject to utilization review, you or your physician must initiate the pre-service review at least three working days prior to when you are scheduled to receive services. The toll-free telephone number for pre-service reviews is 1-800-274-7767.If you do not receive the certified service within 60 days of the certification, or if the nature of the service changes, a new pre-service review must be obtained.
2. The *claims administrator* will certify services that are *medically necessary* and appropriate. For inpatient *hospital* stays, the *claims administrator* will, if appropriate, certify a specific length of *stay* for approved services. You, your *physician* and the provider of the service will receive a written confirmation showing this information.

Concurrent Reviews

1. If pre-service review was not performed, you or the provider of the service must contact the *claims administrator* for concurrent review. For an *emergency* admission or procedure, the *claims administrator* must be notified within one working day of the admission or procedure. The toll-free number is printed on your identification card.
2. When the *claims administrator* determines that the service is *medically necessary* and appropriate, they will, depending upon the type of treatment or procedure, certify the service for a period of time that is medically appropriate. The *claims administrator* will also determine the medically appropriate setting.
3. If it is determined that the service is not *medically necessary* and appropriate, your *physician* will be notified by telephone no later than 24 hours following the *claims administrator's* decision. The *claims administrator* will send written notice to you and your *physician* within two business days following the decision. However, care will not be discontinued until your *physician* has been notified and a plan of care that is appropriate for your needs has been agreed upon.

Retrospective Reviews

1. Retrospective review is performed when the *claims administrators* are not notified of the service you received, and are therefore unable to perform the appropriate review prior to your discharge from the *hospital*. It is also performed when pre-service or concurrent review has been done, but services continue longer than originally certified.

   It may also be performed for the evaluation and audit of medical documentation after services have been provided, whether or not pre-service or concurrent review was performed.
2. Such services which have been retroactively determined to not be *medically necessary* and appropriate will be retrospectively denied certification.

AUTHORIZATION PROGRAM

The authorization program provides prior authorization for certain "special services".

It is your responsibility to obtain authorization before you receive any service subject to the authorization program. The toll-free number to call for authorization is shown on your plan identification card. If you receive any such service, and do not follow the procedures set forth in this section, your benefits will be reduced as shown in the "Effect on Benefits" portion of **AUTHORIZATION PROGRAM.**

Services Requiring Authorization

1. Hepatitis B immunizations.
2. Home health care.
3. Home infusion therapy.
4. Organ and tissue transplants.
5. Rental or purchase of Durable Medical Equipment over $1,000.
6. Skilled nursing facility.

*Effec*t on Benefits

Benefits for special services subject to prior authorization will be provided as stated in this *plan* for the specific service only when authorization has been obtained as required. No benefits are payable for unauthorized special services.

When Authorization Will Be Provided

1. **Hepatitis B Immunizations.** Hepatitis B immunization once every five years for beneficiaries in a high risk category as stated in the "Additional Inoculations and Immunizations" provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED. Hepatitis B immunization will be authorized if:
    a. It is *medically necessary*.
    b. You or your *physician* requests approval for the additional benefits prior to those services being rendered.
2. **Home Health Care.** Authorizations for home health care services will be provided only if the following criteria are met:
    a. The services are *medically necessary* and appropriate and can be safely provided in the *beneficiary's* home, as certified by the attending *physician*.
    b. The attending *physician* manages and directs the *beneficiary's* medical care at home.
    c. The attending *physician* must establish a definitive treatment plan which must be consistent with the *beneficiary's* medical needs and must list the services to be provided by the *home health agency*.
3. **Home Infusion Therapy.** Authorizations for services by a *home infusion therapy provider* will be provided only if the following criteria are met:
    a. The services are *medically necessary* and appropriate*;* and
    b. The attending *physician* has submitted both a prescription and a plan of treatment prior to services being rendered.
4. **Organ and Tissue Transplants.** Authorizations for organ and tissue transplants will be provided only if both of the following criteria are met:

a. The services are *medically necessary;* and

b. The *physicians* on the surgical team and the facility in which the transplant is to take place are approved for the transplant requested.

5. **Rental or purchase of Durable Medical Equipment over $1,000.** Authorizations for rental or purchase of durable medical equipment over **$1,000** as shown under "Durable Medical Equipment" provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED will be provided only if the following criteria are met:

   a. The services or supplies are *medically necessary* and appropriate*;* and

   b. The attending *physician* has submitted both a prescription and a plan of treatment prior to services or supplies being rendered.

6. **Skilled Nursing Facility.** The *claims administrator* will authorize inpatient services provided in a *skilled nursing facility* if:

   a. You require daily skilled nursing or rehabilitation, as certified by the attending *physician*;

   b. You were an inpatient in a *hospital* for at least three consecutive days, and are to be admitted to the *skilled nursing facility* within 30 days of your discharge from the *hospital*; and

   c. You will be treated for the same condition for which you were treated in the *hospital*.

How to Obtain an Authorization

You or your *physician* must call the toll-free telephone number printed on your identification card before the services are rendered.

THE MEDICAL NECESSITY REVIEW PROCESS

The *claims administrator* will work with you and your health care providers to cover *medically necessary* and appropriate care and services. While the types of services requiring review and the timing of the reviews may vary, the *claims administrator* is committed to ensuring that reviews are performed in a timely and professional manner. The following information explains the review process.

1. A decision on the medical necessity of a pre-service request will be made no later than 2 business days from receipt of the information necessary to make the decision.

2. A decision on the medical necessity of a concurrent request will be made no later than one business day from receipt of the information necessary to make the decision.

3. A decision on the medical necessity of a retrospective review will be made and communicated in writing no later than 30 days from receipt of the information necessary to make the decision.

4. If the *claims administrator* does not have the information they need, they will make every attempt to obtain that information from you or your *physician*. If unsuccessful and a delay is anticipated, the *claims administrator* will notify you and your *physician* of the delay and what is needed to make a decision. The *claims administrator* will also inform you of when a decision can be expected following receipt of the needed information.

5. All pre-authorization, pre-service, concurrent and retrospective reviews for medical necessity are screened by clinically experienced, licensed personnel (called "Review Coordinators") using pre-established criteria and the *claims administrator's* medical policy. These criteria and policies are developed and approved by practicing providers not employed by the *claims administrator*, and are evaluated at least annually and updated as standards of practice or technology changes. Requests satisfying these criteria are certified as *medically necessary*. Review Coordinators are able to approve most requests.

6. A written confirmation including the specific service certified as *medically necessary* will be sent to you and your provider no later than 2 business days after the decision.

7. If the request fails to satisfy these criteria or medical policy, the request is referred to a Peer Clinical Reviewer. Peer Clinical Reviewers are health professionals clinically competent to evaluate the specific

clinical aspects of the request and render an opinion specific to the medical condition, procedure and/or treatment under review. Peer Clinical Reviewers are licensed in California with the same license category as the requesting provider. When the Peer Clinical Reviewer is unable to certify the service, the requesting *physician* is contacted by telephone for a discussion of the case. In many cases, services can be certified after this discussion. If the Peer Clinical Reviewer is still unable to certify the service, your provider will be given the option of having the request reviewed by a different Peer Clinical Reviewer.

8. Only the Peer Clinical Reviewer may determine that the proposed services are not *medically necessary* and appropriate. Your *physician* will be notified by telephone within 24 hours of a decision not to certify and will be informed at that time of how to request reconsideration. Written notice will be sent to you and the requesting provider within two business days of the decision. This written notice will include:
    - An explanation of the reason for the decision,
    - Reference of the criteria used in the decision to modify or not certify the request,
    - The name and phone number of the Peer Clinical Reviewer making the decision to modify or not certify the request,
    - How to request reconsideration if you or your provider disagree with the decision.
9. Reviewers may be plan employees or an independent third party chosen at the sole and absolute discretion of the *claims administrator*.
10. You or your *physician* may request copies of specific criteria and/or medical policy by writing to the address shown on your plan identification card. Medical necessity review procedures may be disclosed to health care providers through provider manuals and newsletters.

A determination of medical necessity does not guarantee payment or coverage. The determination that services are *medically necessary* is based on the clinical information provided. Payment is based on the terms of your coverage at the time of service. These terms include certain exclusions, limitations, and other conditions. Payment of benefits could be limited for a number of reasons, including:

- The information submitted with the claim differs from that given by phone; or
- The service is excluded from coverage; or
- You are not eligible for coverage when the service is actually provided.

PERSONAL CASE MANAGEMENT

The personal case management program enables you to obtain medically appropriate care in a more economical, cost-effective and coordinated manner during prolonged periods of intensive medical care. The *claims administrator,* through a case manager, may recommend an alternative plan of treatment, which may include services not covered under this *plan*. The *plan administrator* does not have an obligation to provide personal case management. These services are provided at the sole and absolute discretion of the *claims administrator*.

How Personal Case Management Works

You may be identified for possible personal case management through the *plan's* utilization review procedures, by the attending *physician, hospital* staff, or the *claims administrator's* claims reports. You or your family may also call the *claims administrator*.

Benefits for personal case management will be considered only when all of the following criteria are met:

1. You require extensive long-term treatment;
2. The *claims administrator* anticipates that such treatment utilizing services or supplies covered under this *plan* will result in considerable cost;
3. A cost-benefit analysis determines that the benefits payable under this *plan* for the alternative plan of treatment can be provided at a lower overall cost than the benefits you would otherwise receive under this *plan* while maintaining the same standards of care; and

4. You (or your legal guardian) and your *physician* agree, in a letter of agreement, with the *claims administrator's* recommended substitution of benefits and with the specific terms and conditions under which alternative benefits are to be provided.

Alternative Treatment Plan. If the claims administrator determines that your needs could be met more efficiently, an alternative treatment plan may be recommended. This may include providing benefits not otherwise covered under this plan. A case manager will review the medical records and discuss your treatment with the attending *physician,* you and your family.

The *claims administrators* make treatment recommendations only; any decision regarding treatment belongs to you and your *physician*. The *plan* will, in no way, compromise your freedom to make such decisions.

Effect On Benefits

1. Any alternative benefits are accumulated toward any *plan* maximums.
2. Benefits are provided for an alternative treatment plan on a case-by-case basis only. The *plan administrator* and *claims administrator* have absolute discretion in deciding whether or not to authorize services in lieu of benefits for any *beneficiary,* which alternatives may be offered and the terms of the offer.
3. Any authorization of services in lieu of benefits in a particular case in no way commits the *claims administrator* to do so in another case or for another *beneficiary*.
4. The personal case management program does not prevent the *claims administrator* from strictly applying the expressed benefits, exclusions and limitations of this *plan* at any other time or for any other *beneficiary*.

Note: The *claims administrator* reserves the right to use the services of one or more third parties in the performance of the services outlined in the letter of agreement. No other assignment of any rights or delegation of any duties by either party is valid without the prior written consent of the other party.

Disagreements With Medical Management Decisions

1. If you or your *physician* disagree with a decision, or question how it was reached, you or your *physician* may request reconsideration. Requests for reconsideration (either by telephone or in writing) must be directed to the reviewer making the determination. The address and the telephone number of the reviewer are included on your written notice of determination. Written requests must include medical information that supports the medical necessity of the services.

1. If you, your representative, or your *physician* acting on your behalf find the reconsidered decision still unsatisfactory, a request for an appeal of a reconsidered decision may be submitted in writing to Anthem Blue Cross Life and Health.

Quality Assurance Of Medical Management

Medical management programs are monitored, evaluated, and improved on an ongoing basis to ensure consistency of application of screening criteria and medical policy, consistency and reliability of decisions by reviewers, and compliance with policy and procedure including but not limited to timeframes for decision making, notification and written confirmation. The Board of Directors is responsible for medical necessity review processes through its oversight committees including the Strategic Planning Committee, Quality Management Committee, and Physician Relations Committee. Oversight includes approval of policies and procedures, review and approval of self-audit tools, procedures, and results. Monthly process audits measure the performance of reviewers and Peer Clinical Reviewers against approved written policies, procedures, and timeframes. Quarterly reports of audit results and, when needed, corrective action plans are reviewed and approved through the committee structure.

COMPLAINTS

All complaints and disputes relating to coverage under this *plan* must be resolved in accordance with the *plan's* grievance procedures. Grievances may be made by telephone (please call the number described on your Identification Card) or in writing (write to **Anthem Blue Cross Life and Health** P.O. Box 60007 Los Angeles, CA 90060-0007 marked to the attention of the Customer Service Department named on your identification card).

All grievances received under the *plan* will be acknowledged in writing, together with a description of how the *plan* proposes to resolve the grievance.

APPEAL

If you have exhausted the grievance and appeals process through Anthem Blue Cross Life and Health and still wish to submit your request for an appeal to the *plan administrator*, submit the request for an appeal in writing to the County of Sonoma Human Resources Director for consideration.

BINDING ARBITRATION

Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to this *plan* or breach or rescission thereof, or in relation to care or delivery of care, including any claim based on contract, tort, or statute, must be resolved by arbitration.

The Federal Arbitration Act will govern the interpretation and enforcement of all proceedings under this Binding Arbitration provision. To the extent that the Federal Arbitration Act is inapplicable, or is held not to require arbitration of a particular claim, state law governing agreements to arbitrate will apply.

The *beneficiary* and the *plan administrator* agree to be bound by this Binding Arbitration provision and acknowledge that they are each giving up their right to a trial by court or jury.

The *beneficiary* and the *plan administrator* agree to give up the right to participate in class arbitration against each other. Even if applicable law permits class arbitration, the *beneficiary* waives any right to pursue, on a class basis, any such controversy or claim against the *plan administrator* and the *plan administrator* waives any right to pursue on a class basis any such controversy or claim against the *beneficiary*.

The arbitration findings will be final and binding except to the extent that state or Federal law provides for the judicial review of arbitration proceedings.

The arbitration is begun by the *beneficiary* making written demand on the *plan administrator*. The arbitration will be conducted by a neutral arbitration entity, by mutual agreement of the *beneficiary* and the *plan administrator*. The arbitration will be held at a time and location mutually agreeable to the beneficiary and the *plan administrator*.

HIPAA PRIVACY REGULATION REQUIREMENTS

This *plan* has been modified as required under the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), to allow the Disclosure of Protected Health Information (PHI) as defined under HIPAA, to the Plan Administrator .

This *plan* will generally use the beneficiaries Protected Health Information (PHI) to the extent of and in accordance with the Uses and Disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, this *plan* will Use and Disclose the Covered Persons' PHI for purposes related to health care Treatment, Payment for health care and Health Care Operations. Additionally, this *plan* will Use and Disclose the Covered Persons' PHI as required by law and as permitted by authorization. Refer to the *plan's* privacy notice for more information about the permitted Uses and Disclosure of PHI, the individuals' right and this Plan's legal duties regarding PHI.

The USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION UNDER HIPAA within this section of the document specifies the terms under which the *plan* may share PHI with the Plan Sponsor, and limits the Uses and Disclosures that the Plan Sponsor may make of the Covered Persons' PHI. The Plan Sponsor will ensure that adequate separation exists between this *plan* and the Plan Sponsor and that proper safeguards are established. This includes specifically identifying the Employee (s) or classes of Employees who will have access to PHI.

This *plan* agrees that it will only disclose the Covered Persons' PHI to the Plan Sponsor upon receipt of a certification from the Plan Sponsor that the terms contained in the USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION UNDER HIPAA portion of this section have been adopted and that the Plan Sponsor

agrees to abide by these terms.

Use And Disclosure Of Protected Health Information Under HIPAA

This section establishes the terms under which the *plan* may share the Covered Persons' PHI with the Plan Sponsor, and limits the Uses and Disclosure that the Plan Sponsor may make of the Covered Persons' PHI. This *plan* shall disclose the Covered Persons' PHI to the Plan Sponsor only to the extent necessary for the purposes of Plan Administrative Functions.

The Plan Sponsor shall Use and/or Disclose the Covered Persons' PHI only to the extent necessary to perform Plan Administrative Functions which include Payment for health care or Health Care Operations performed on behalf of this *plan.*

This *plan* agrees that it will only Disclose the Covered Persons' PHI to the Plan Sponsor upon receipt of a certification from the Plan Sponsor that the terms of this section have been adopted and that the Plan Sponsor agrees to abide by these terms.

The Plan Sponsor is subject to ALL of the following restrictions that apply to the Use and Disclosure of the Covered Persons' PHI. The Plan Sponsor:

a) Will only Use and Disclose the Covered Persons' PHI for Plan Administrative Functions, as permitted or required by plan documents or as required by law.

b) Will require each of its subcontractors or agents to whom the Plan Sponsor may provide the Covered Persons' PHI to agree to the same restrictions and conditions imposed on the Plan Sponsor with regard to their PHI;

c) Will not Use or Disclose PHI for employment-related actions and decisions or in connection with any other of the Plan Sponsor's benefits or Employee benefit plans;

d) Will promptly report to this Plan any impermissible or improper Use or Disclosure of PHI not authorized by the Plan documents, of which the Plan Sponsor becomes aware;

e) Will allow the Covered Person or this *plan* to inspect and copy any PHI about the Covered Person contained in the Designated Record Set that is in the Plan Sponsor's custody or control, in accordance with HIPAA Regulations at §164.524.

f) Will amend or correct, or make available to the *plan* to amend or correct, any portion of the Covered Persons' PHI contained in the Designated Record Set to the extent permitted or required in accordance with the HIPAA regulations at §164.526;

g) Will keep a Disclosure log for certain types of Disclosures in accordance with the HIPAA Regulations at §164.528. The Covered Person has a right to see the Disclosure log. The Plan Sponsor does not have to maintain a log if Disclosures are for certain Plan related purposes such as Payment of benefits or Health Care Operations;

h) Will make its internal practices, books and records relating to the Use and Disclosure of the Covered Persons' PHI available to this *plan* and to the Department of Health and Human Services or its designee for the purpose of determining this Plan's compliance with HIPAA;

i) Must, if feasible, return to this *plan* or destroy all of the Covered Persons' PHI that the Plan Sponsor received from or on behalf of this *plan* when the Plan Sponsor no longer needs their PHI to administer this *plan.* This includes all copies in any form, including any compilations derived from the PHI. If return or destruction is not feasible, the Plan Sponsor agrees to restrict and limit further Uses and Disclosures to the purposes that make the return or destruction infeasible;

j) Will ensure that adequate separation exists between this *plan* and the Plan Sponsor so that the Covered Persons' PHI will be used only for the purpose of Plan Administrative Functions;

k) Will use reasonable efforts to request only the minimum necessary type and amount of the Covered

Persons' PHI to carry out functions for which the information is requested.

This *plan* requires the Plan Sponsor to certify that the following classes of employees whose responsibility is the administration of employee benefits, e.g. County Privacy Officer, Risk Manager, Risk Management Analyst III, Risk Management Analyst I/II, Administrative Aide, Senior Office Assistant, Department Analyst, Account Clerk I/II and Receptionist, are the only Employee(s) who will access and use and disclose the Covered Persons' PHI. The Plan Sponsor must further certify that such Employees will only access and use and disclose PHI for the purposes set forth to perform necessary Plan Administrative Functions. This list includes every class of Employee or other workforce members under the control of the Plan Sponsor who may receive the Covered Persons' PHI. If any of these Employees or workforce members Use or Disclose the Covered Persons' PHI in violation of the terms set forth in this section, the Employees or workforce members will be subject to disciplinary action and sanctions, including the possibility of termination of employment, as required by law. If the Plan Sponsor becomes aware of any such violations, the Plan Sponsor will promptly report the violation to this *plan* and will cooperate with the *plan* to correct the violation, to impose the appropriate sanctions, and to mitigate any harmful effects to the Covered Person.

Defined Terms For HIPAA Privacy Regulation Requirements

Administrative Simplification is the section of the law that addresses electronic transactions, privacy and security. The goals are to:

- Improve efficiency and effectiveness of the health care system;
- Standardize electronic data interchange of certain administrative transactions;
- Safeguard security and privacy of Protected Health Information;
- Improve efficiency to compile/analyze data, audit, and detect fraud; and
- Improve the Medicare and Medicaid programs.

Business Associate are entities (i.e. Anthem Blue Cross Life and Health) that perform or assist in the performance of any of the activities or functions of the Covered Entity involving the Use and Disclosure of Individually Identifiable Health Information, including claim processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing, benefit management, practice management, repricing, legal, actuarial, accounting, consulting, data aggregation management, administrative accreditation or financial services.

Covered Entities are entities directly impacted by the limitations placed on the access, Use and Disclosure of PHI. They include:

- Health care providers who transmit any health information in electronic form in connection with a transaction covered by the HIPAA regulations;
- Health Plans that provide reimbursement or Payment for such health care services; and
- Health care clearinghouses that transmit PHI in electronic format as part of the HIPAA electronic data interchange (EDI) requirements.

De-identified is information that does not identify an individual and under which no reasonable basis exists to believe that the information can be used to identify an individual.

Designated Record Set means a set of records maintained by or for a Covered Entity that includes a Covered Persons' PHI. This includes medical records, billing records, enrollment, Payment, claims adjudication and case management record systems maintained by or for this Plan. This also includes records used to make decisions about Covered Persons. This record set must be maintained for a minimum of 6 years.

Disclosure is the release or divulgence of information by an entity to persons or organizations outside that entity.

Health Care Operations include general administrative and business functions necessary for the Covered Entity to remain a viable business. These activities include:

- Conducting quality assessment and improvement activities;

- Reviewing the competence or qualifications and accrediting/licensing of health care professionals and plans;
- Evaluating health care professional and health plan performance,
- Training future health care professionals;
- Insurance activities relating to the renewal of a contract for insurance;
- Conducting or arranging for medical review and auditing services;
- Customer service, including the resolution of internal grievances;
- Compiling and analyzing information in anticipation of or for use in a civil or criminal legal proceeding;
- Population-based activities related to improving health or reducing health care costs, protocol development, case management and care coordination;
- Contacting of health care providers and patients with information about treatment alternatives, and related functions that do not entail direct patient care; and
- Activities related to the creation, renewal or replacement of a contract for health insurance or health benefits, as well as ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss and excess of loss insurance).

Individually Identifiable Health Information is information that is a subset of health information, including demographic information collected from a Covered Person, and that:

- Is created by or received from a Covered Entity;
- Relates to the past, present, or future physical or mental health or condition of a Covered Person, the provision of health care, or the past, present, or future Payment for the provision of health care; and
- Identifies the Covered Person, or with respect to which there is reasonable basis to believe the information can be used to identify the Covered Person.

Payment means the activities of the Health Plan, health care provider or a Business Associate, including the actual Payment under the policy or contract; and a health care provider or its Business Associate that obtains reimbursement for the provision of health care.

Plan Administrative Functions means administrative functions of Payment or Health Care Operations performed by the Plan Sponsor on behalf of the Plan including quality assurance, claims processing, auditing and monitoring.

Privacy Official is the individual who provides oversight of compliance with all policies and procedures related to the protection of PHI and federal and state regulations related to a Covered Person's privacy.

Protected Health Information (PHI) is Individually Identifiable Health Information that is transmitted by electronic media; or maintained in any medium that is considered electronic media, or transmitted or maintained in any other form or medium.

Summary Health Information is information that may be Individually Identifiable Health Information that summarizes claims history, claims experience or the type of claims experience of a Covered Person with the following identifiers removed:

- Names;
- Geographic units - information more specific than a state (five-digit zip codes are allowed);
- Dates – any month or day (except the year) directly relating to individuals or their treatment including birth date, admission date, or date of death. Listing the individuals' age is allowed with the exception of individuals over the age of 89. For individuals over the age of 89, any month, day or year that reveals the individuals' age to be over 89, must be removed;
- Numbers - Social Security numbers, phone numbers, fax numbers, vehicle identifiers and all other identifying numbers as required by the regulations.

Treatment is the provision of health care by, or the coordination of health care (including health care management of the individual through risk assessment, case management, and disease management) among health care providers; the referral of a patient from one provider to another; or the coordination of health care or other services among health care providers and third parties authorized by the health plan or the individual.

Use means, with respect to Individually Identifiable Health Information, the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information.

NOTICE OF PRIVACY PRACTICES[2]

This Notice Describes How Medical Information About You May Be Used And Disclosed And How You Can Get Access To This Information. Please Review It Carefully.

Your Privacy is Important to Us

Because we understand that medical information about you and your family members is personal, the County of Sonoma staff is committed to protecting your medical information.

This notice will tell you about the ways in which we may use and disclose medical information about you. This notice also describes your rights and certain obligations we have regarding the use and disclosure of your medical information.

The County of Sonoma contracts with Anthem Blue Cross Life and Health and CVS/Caremark to administer the benefits of the County Health Plan. Anthem Blue Cross Life and Health and CVS/Caremark provides medical information to the County, such as claims experience reports. These reports allow the County to perform the actuarial functions necessary to evaluate plan performance and benefits, and to establish premiums.
The County of Sonoma is required by law to:

- Make sure that medical information that identifies you is protected from inappropriate use and disclosure.
- Give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the notice that is currently in effect.

Changes to Our Privacy Practices

We reserve the right to change our privacy practices. We reserve the right to apply the revised practices to the medical information we already have about you as well as any information we receive after the revisions are made. A copy of the most current notice is available from the County of Sonoma Human Resources Department. The effective date of the notice is on first page of the Notice of Privacy Practices in the top right-hand corner.

The Following Information Describes The Ways That *Anthem Blue Cross Life and Health -And CVS/Caremark* May Use And Disclose Your Medical Information.

For Treatment

Anthem Blue Cross Life and Health and CVS/Caremark may use and disclose your medical information to provide, coordinate and manage your health care benefits and any related services. Anthem Blue Cross Life and Health and CVS/Caremark may disclose your medical information to doctors, nurses, technicians, therapists and health care personnel who are involved in your care. Doctors and health care providers are permitted to share information about your care to help provide you with timely and appropriate health care services. For example, health care providers may share your medical information in order to coordinate the different things you need, such as prescriptions, lab work and x-rays.

For Payment

Anthem Blue Cross Life and Health and CVS/Caremark may use and disclose medical information about you to doctors and other health care providers that request eligibility information or treatment authorizations. Anthem Blue Cross Life and Health also uses and discloses your health information so that your health care providers can bill and be paid by for the health care services you receive.

For Health Care Operations

Anthem Blue Cross Life and Health may use and disclose medical information about you for our health care operations. For example, Anthem Blue Cross Life and Health may use medical information to review and evaluate

[2] Effective April 14, 2003

the benefits and services provided by the County Health Plan. Anthem Blue Cross Life and Health may use your medical information to tell you about possible treatment options or alternatives or to tell you about health-related products or services that may be of interest to you. Anthem Blue Cross Life and Health may use your medical information to contact you as a reminder that you should make an appointment for treatment or medical care.

As Required by Law

Anthem Blue Cross Life and Health may use and disclose medical information about you as required by law. For example, disclosures of medical information may be required for the following purposes:

- For judicial and administrative proceedings pursuant to legal authority.
- To assist law enforcement officials in their law enforcement duties.

Health Oversight Activities

Your health information may be disclosed for health oversight activities authorized by law, such as audits, investigations and inspections. Health oversight activities are conducted by state and federal agencies that oversee government benefit programs and civil rights compliance.

Organ/Tissue Donation

If you are an organ donor, Anthem Blue Cross Life and Health may disclose your health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.

Health and Safety

Your health information may be disclosed to avert a serious threat to your health or safety or that of any other person pursuant to applicable law.

Active Military, Veterans, National Security and Intelligence

If you are or were a member of the armed forces, or part of the national security or intelligence communities, Anthem Blue Cross Life and Health will disclose your health information when required by military command or other government authorities.

Worker's Compensation

Your health information may be used or disclosed in order to comply with laws and regulations related to Worker's Compensation.

Other Uses and Disclosures of Medical Information

The County of Sonoma and Anthem Blue Cross Life and Health use and disclose your medical information in a manner that complies with federal and state laws and regulations. When an authorization is required to use or disclose your medical information, such as, for the use and disclosure of inpatient mental health records, HIV test results, or substance abuse records, the use or disclosure will be made only with your written authorization. If you authorize the use and disclosure of your medical information, you may revoke that authorization, in writing, at any time. If you revoke your authorization, all uses or disclosures of your medical information for the purposes covered by your written authorization will cease unless we have already acted in reliance on your authorization. We are unable to take back any disclosures we have already made prior to revoking your authorization.

Your Individual Rights Regarding Your Medical Information

If you have any questions about this Notice or your individual rights regarding medical information maintained by the County of Sonoma, please contact the County of Sonoma Compliance/Privacy Officer at (707) 565 – 4999. All requests to exercise your individual rights and privacy related complaints must be submitted in writing to:

County of Sonoma Compliance/Privacy Officer
3313 Chanate Road
Santa Rosa, CA 95404

Your Right to Inspect and Copy

You have the right to inspect and copy medical information maintained by the County of Sonoma that may be used to make decisions about your care. Usually, this includes medical and billing records, but may not include some mental health information.

If you request a copy of the information, you will be charged a fee for the costs of copying, mailing or other supplies associated with your request. We will notify you of the cost involved and you may choose to withdraw or modify your request before any costs are incurred.

We may deny your request to inspect and copy certain medical information in very limited circumstances. A denial to of a request to inspect or copy medical information can only be made by licensed health care professionals. If your request to inspect and copy medical information is denied, you may request that the denial be reviewed. Another licensed health care professional chosen by the Compliance/Privacy Officer will review your request and the denial. The licensed health care professional conducting the review will not be the same licensed health care professional who denied your initial request. We will comply with the outcome of the review.

Your Right to Amend

If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by the County of Sonoma.

You must provide the reason that you are requesting the amendment. We will deny your request for an amendment if it is not in writing or it does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or organization that created the information is no longer available to make the amendment.
- Is not part of the medical information kept by or for the County of Sonoma.
- Is not part of the information, which you would be permitted to inspect and copy.
- Is accurate and complete.

Even if we deny your request for amendment, you have the right to submit a written addendum, not to exceed 250 words, with respect to any item or statement in your record you believe is incomplete or incorrect. If you clearly indicate in writing that you want the addendum to be made part of your medical record we will attach it to your records and include it whenever we make a disclosure of the item or statement you believe to be incomplete or incorrect.

Your Right to an Accounting of Disclosures

You have the right to request an accounting of disclosures we made of medical information about you, other than disclosures for treatment, payment, health care operations, or pursuant to a valid authorization.

Your request must include a time period. The time period may not be longer than six years and may not include dates prior to April 14, 2003. Your request should indicate in what form you want the list of disclosures (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request before any costs are incurred.

Your Right to Request Restrictions

You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request to receive communications about your health care by an alternate means or at alternative locations.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment or for the purposes of public health reporting or as required by law. We will accommodate all reasonable requests. If you wish to request a restriction or limitation on the use or disclosure of your medical information, your written request must tell us:

- What information you want to limit.
- Whether you want to limit our use, disclosure or both.
- To whom you want the limits to apply, for example, disclosures to your *spouse*.

If you wish to request that communications regarding your medical information be provided using alternate means or locations, your written request must specify:

- How or where you wish to be contacted.
- The method you would like us to use to communicate with you, for example, the alternative address, phone number or email address.

Your Right to Receive a Paper Copy of This Notice

You may ask us to give you a copy of this notice at any time. You may request that a copy be sent to you by contacting the County of Sonoma Compliance Message Line at (707) 565 – 4999. Please state that you wish to receive a Notice of Privacy Practices and provide your name and mailing address. A copy will be sent to you within 5 business days of your request or you may obtain a copy of this notice at www.sonoma-county.org.

Complaints

If you believe your privacy rights related to the management of your health information maintained by the County of Sonoma have been violated you may file a complaint with our Compliance/Privacy Officer or with the Secretary of the Department of Health and Human Services. To file a complaint with the County of Sonoma please submit your complaint to:

County of Sonoma Compliance /Privacy Officer
3313 Chanate Road
Santa Rosa, CA 95404

GENERAL PROVISIONS

Amendment and Termination. In order that the *plan* may carry out its obligation to maintain, within the limits of its resources, a program dedicated to providing the maximum possible benefits for all employees, the County of Sonoma Board of Supervisors expressly reserves the right, in its sole discretion at any time, but upon a non-discriminatory basis, except as may be specifically contradicted otherwise in an applicable Memorandum of Understanding (MOU):

a) To terminate or amend either the amount or condition with respect to any benefit even though such termination or amendment affects claims which have already accrued; and

b) To alter or postpone the method of payment of any benefit;

c) To amend or rescind any other provisions of this *plan*.

Amendments shall be made by resolution of the County of Sonoma Board of Supervisors, except as listed below.

The County of Sonoma Human Resources Director has the authority to amend this *plan*'s Summary Plan Description in the following circumstances; 1) to reflect any changes agreed to by an employee organization and the County Board of Supervisors, 2) to update any vendor or vendor contact information, and 3) to correct any unintended clerical or administrative errors.

Providing of Care. We are not responsible for providing any type of *hospital,* medical or similar care, nor are we responsible for the quality of any such care received.

Independent Contractors. The *claims administrator's* relationship with providers is that of an independent contractor. *Physicians,* and other health care professionals, *hospitals, skilled nursing facilities* and other community agencies are not the *claims administrator's* agents nor is the *claims administrator*, or any of the employees of the *claims administrator*, an employee or agent of any *hospital,* medical group or medical care provider of any type.

Non-Regulation of Providers. The benefits of this *plan* do not regulate the amounts charged by providers of medical care, except to the extent that rates for covered services are regulated with *participating providers*.

Out-of-California Providers. The Blue Cross and Blue Shield Association, of which the *claims administrator* is a member, has a program (called the "BlueCard Program") which allows our *beneficiaries* to have the reciprocal use of participating providers contracted under other states' Blue Cross and/or Blue Shield Licensees. If you are outside of California and require medical care or treatment, you may use a local Blue Cross and/or Blue Shield provider. If you use one of these providers, your out-of-pocket expenses may be lower than those incurred when using a provider that does not participate in the BlueCard Program. The rules for the BlueCard Program, including those described below, are set by The Blue Cross and Blue Shield Association. In order for you to receive access to whatever discounts may be available, we must abide by those rules.

When you obtain covered health care services through the BlueCard Program outside of California, the amount you pay, if it is not a flat dollar amount, is usually calculated on the lower of the:

- Billed charges for your covered services, or;
- Negotiated price that the on-site Blue Cross and/or Blue Shield Licensee ("Host Blue") passes on to us.

Often, this "negotiated price," referred to above, will consist of a simple discount which reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors in expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect average expected savings with your health care provider or with a specified group of providers. If the negotiated price reflects average expected savings, it may result in greater variation (more or less) from the actual price paid than will the estimated price. The estimated or average price may be adjusted in the future to correct for over or underestimation of past prices. Regardless of how the negotiated price is determined, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating *beneficiary* liability for covered services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate *beneficiary* liability calculation methods that differ from the usual BlueCard Program method noted above in the second paragraph of this section or require a surcharge, the *claims administrator* would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

Providers available to you through the BlueCard Program have not entered into contracts with Anthem Blue Cross Life and Health. If you have any questions or complaints about the BlueCard Program, please call the customer service telephone number listed on your ID card.

Terms of Coverage

1. In order for you to be entitled to benefits under the *plan,* both the *plan* and your coverage under the *plan* must be in effect on the date the expense giving rise to a claim for benefits is incurred.
2. The benefits to which you may be entitled will depend on the terms of coverage in effect on the date the expense giving rise to a claim for benefits is incurred. An expense is incurred on the date you receive the service or supply for which the charge is made.

Protection of Coverage. We do not have the right to cancel your coverage under this *plan* while: (1) this *plan* is in effect; (2) you are eligible; and (3) your required contributions are paid according to the terms of the *plan*.

Free Choice of Provider. This *plan* in no way interferes with your right as a *beneficiary* entitled to *hospital* benefits to select a *hospital*. You may choose any *physician* who holds a valid *physician* and surgeon's certificate and who is a member of, or acceptable to, the attending staff and board of directors of the *hospital* where services are received. You may also choose any other health care professional or facility which provides care covered under this *plan,* and is properly licensed according to appropriate state and local laws. But your choice may affect the benefits payable according to this *plan*.

Continuity of Care. If the *claims administrator* terminates its contractual relationship with a *participating provider* and you are undergoing a course of treatment from that provider at the time the contract is terminated, you may be able to continue to receive services from that provider (but only if such provider agrees to continue to comply with the same contractual requirements that applied prior to termination). To qualify, you must have an acute or a serious chronic condition, a high risk pregnancy, or a pregnancy in the second or third trimester. You may request this continuity of care by calling the customer service telephone number listed on your ID card. If approved,

services may be received for a limited period of time, but no longer than 90 days, unless you cannot be safely transferred to a *participating provider*. Coverage is provided according to the terms and conditions of this *plan* applicable to *participating providers*.

Medical Necessity. The benefits of this *plan* are provided only for services which the *claims administrator* determines to be *medically necessary*. The services must be ordered by the attending *physician* for the direct care and treatment of a covered condition. They must be standard medical practice where received for the condition being treated and must be legal in the United States. The process used to authorize or deny health care services under this *plan* is available to you upon request.

Expense in Excess of Benefits. We are not liable for any expense you incur in excess of the benefits of this *plan*.

Benefits Not Transferable. Only the *beneficiary* is entitled to receive benefits under this *plan*. The right to benefits cannot be transferred.

Notice of Claim. You or the provider of service must send the *claims administrator* properly and fully completed claim forms within 90 days of the date you receive the service or supply for which a claim is made. If it is not reasonably possible to submit the claim within that time frame, an extension of up to 12 months from date of service will be allowed. The *plan administrator* is not liable for the benefits of the *plan* if you do not file claims within the required time period. The *plan administrator* will not be liable for benefits if the *claims administrator* does not receive written proof of loss on time.

Services received and charges for the services must be itemized, and clearly and accurately described. Claim forms must be used; canceled checks or receipts are not acceptable.

Timely Payment of Claims. Any benefits due under this *plan* shall be due once the *claims administrator* has received proper, written proof of loss, together with such reasonably necessary additional information the *claims administrator* may require to determine our obligation.

Payment to Providers. The benefits of this *plan* will be paid directly to *participating providers* .

Right of Recovery. When the amount we paid exceeds our liability under this *plan,* we have the right to recover the excess amount. This amount may be recovered from you, the person to whom payment was made or any other plan.

Plan Administrator - COBRA. In no event will the *claims administrator* be *plan administrator* for the purposes of compliance with the Consolidated Omnibus Budget Reconciliation Act (COBRA). The term "*plan administrator*" refers to County of Sonoma or to a person or entity other than the *claims administrator*, engaged by County of Sonoma to perform or assist in performing administrative tasks in connection with the *plan*. The *plan administrator* is responsible for satisfaction of notice, disclosure and other obligations of administrators. In providing notices and otherwise performing under the CONTINUATION OF COVERAGE section of this *plan description*, the *plan administrator* is fulfilling statutory obligations imposed on it by federal law and, where applicable, acting as your agent.

Workers' Compensation Insurance. The *plan* does not affect any requirement for coverage by workers' compensation insurance. It also does not replace that insurance.

Liability to Pay Providers. In the event that the *plan* does not pay a provider who has provided benefits to you, you will be required to pay that provider any amounts not paid to them by the *plan*.

Financial Arrangements with Providers. The *claims administrator* has contracts with certain health care providers and suppliers (hereafter referred to together as “Providers”) for the provision of and payment for health care services rendered to its members and *beneficiaries* entitled to health care benefits under individual certificates and group policies or contracts to which *claims administrator* is a party, including all persons covered under the *plan*.

DISCRETIONARY AUTHORITY OF PLAN ADMINISTRATOR AND DESIGNEES

In carrying out their respective responsibilities under the *plan*, the *plan administrator* or its delegate, other *plan* fiduciaries, and the *claims administrator* of the *plan,* have full discretionary authority to interpret the terms of the *plan* and to determine eligibility and entitlement to *plan* benefits in accordance with the terms of the *plan*. Any interpretation or determination made under that discretionary authority will be given full force and effect, unless it can

be shown that the interpretation or determination was arbitrary and capricious.

DEFINITIONS

The meanings of key terms used in this *plan description* are shown below. Whenever any of the key terms shown below appear, it will appear in italicized letters. When any of the terms below are italicized in your *plan description*, you should refer to this section.

Accidental injury is physical harm or disability that is the result of a specific unexpected incident caused by an outside force. The physical harm or disability must have occurred at an identifiable time and place. Accidental injury does not include illness or infection, except infection of a cut or wound.

Ambulatory surgical center is a freestanding outpatient surgical facility. It must be licensed as an outpatient clinic according to state and local laws and must meet all requirements of an outpatient clinic providing surgical services. It must also meet accreditation standards of the Joint Commission on Accreditation of Health Care Organizations or the Accreditation Association of Ambulatory Health Care.

Beneficiary is the *employee* or *dependent*.

Benefit Year is a 12 month period starting on June 1 at 12:01 a.m. Pacific Standard Time.

Child is a person that meets the *plan's* eligibility requirements for children as outlined under HOW COVERAGE BEGINS AND ENDS.

Claims administrator refers to Anthem Blue Cross Life and Health Insurance Company. On behalf of Anthem Blue Cross Life and Health Insurance Company, Anthem Blue Cross shall perform all administrative services in connection with the processing of medical claims under the *plan.*

Cosmetic surgery or treatment is surgery or other services performed solely for beautification or to alter or reshape normal (including aged) structures or tissues of the body to improve appearance as determined by the *claims administrator* or its designee. Cosmetic surgery does not become reconstructive surgery because of psychological or psychiatric reasons.

Covered expense is the expense you incur for a covered service or supply, but not more than the maximum amounts described in YOUR MEDICAL BENEFITS: HOW COVERED EXPENSE IS DETERMINED. Expense is incurred on the date you receive the service or supply.

Creditable coverage is any individual or group plan that provides medical, hospital and surgical coverage, including continuation or conversion coverage, coverage under a publicly sponsored program such as Medicare or Medicaid, CHAMPUS, the Federal Employees Health Benefits Program, programs of the Indian Health Service or of a tribal organization, a state health benefits risk pool, or coverage through the Peace Corps, the State Children's Health Insurance Program, or a public health plan established or maintained by a state, the United States government or a foreign country. Creditable coverage does not include accident only, credit, coverage for on-site medical clinics, disability income, coverage only for a specified disease or condition, hospital indemnity or other fixed indemnity insurance, Medicare supplement, long-term care insurance, dental, vision, workers' compensation insurance, automobile insurance, no-fault insurance, or any medical coverage designed to supplement other private or governmental plans.

You are considered to have been covered under a creditable coverage if you: (1) were covered under a creditable coverage on the date that coverage terminated; (2) were in an eligible status under this *plan* within 63 days of termination of the creditable coverage; and (3) properly enrolled for coverage within 31 days of the eligibility date.

You are also considered to have been covered under a creditable coverage if your employment ended, the availability of medical coverage offered through employment or sponsored by an employer terminated, or an employer's contribution toward medical coverage terminated, provided that you: (1) were covered under a creditable coverage on the date that coverage terminated; (2) were in an eligible status under this *plan* within 180 days of termination of the creditable coverage; and (3) properly enrolled for coverage within 31 days of the eligibility date.

Custodial care is care provided primarily to meet your personal needs. This includes help in walking, bathing or dressing. It also includes preparing food or special diets, feeding, administration of medicine which is usually self-administered or any other care which does not require continuing services of medical personnel.

Day treatment center is an outpatient psychiatric facility, which is part of or affiliated with a *hospital*. It must be licensed according to state and local laws to provide outpatient care and treatment of *mental or nervous disorders* or substance abuse under the supervision of *physicians*.

Dependent is a person that meets the *plan's* eligibility requirements for dependents as outlined under HOW COVERAGE BEGINS AND ENDS.
Domestic partner is a person that meets the *plan's* eligibility requirements for domestic partners as outlined under HOW COVERAGEBEGINS AND ENDS: HOW COVERAGE BEGINS.

Effective date is the date your coverage begins under this *plan*.

Emergency is a sudden unexpected onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or in the case of a pregnant woman, the health of her unborn child) in serious jeopardy, serious impairment to bodily functions or serious dysfunction/impairment of any bodily organ or part. For psychiatric conditions, the lack of the treatment could reasonably be expected to result in the patient harming himself or herself and/or other persons.

Final determination as to whether services were rendered in connection with an emergency will rest solely with the *claims administrator*.

Emergency services are services provided in connection with the initial treatment of a medical or psychiatric *emergency*.

Employee is the person who, by meeting the *plan's* eligibility requirements for employees, is allowed to choose membership under this *plan* for himself or herself and his or her eligible *dependents*. Such requirements are outlined in HOW COVERAGE BEGINS AND ENDS.

Experimental and/or Investigational. A service or supply will be deemed to be experimental and/or investigational if, in the opinion of the *claims administrator* or its designee, based on the information and resources available at the time the service was performed or the supply was provided, any of the following conditions were present with respect to one or more essential provisions of the service or supply:

1. The service or supply is described as an alternative to more conventional therapies in the protocols (the plan for the course of medical treatment that is under investigation) or consent document (the consent form signed by or on behalf of the patient) of the health care provider that performs the service or prescribes the supply;
2. The prescribed service or supply may be given only with the approval of an Institutional Review Board as defined by federal law;
3. In the opinion of the *claims administrator* or its designee, there is either an absence of authoritative medical, dental or scientific literature on the subject, or a preponderance of such literature published in the United States; and written by experts in the field; that shows that recognized medical, dental or scientific experts: classify the service or supply as experimental and/or investigational; or indicate that more research is required before the service or supply could be classified as equally or more effective than conventional therapies;
4. With respect to services or supplies regulated by the US Food and Drug Administration (FDA), FDA approval is required in order for the service and supply to be lawfully marketed; and it has not been granted at the time the service or supply is prescribed or provided; or a current investigational new drug or new device application has been submitted and filed with the FDA.

In determining if a service or supply is or should be classified as experimental and/or investigational, the *claims administrator* or its designee will rely only on the following specific information and resources that are available at the time the service or supply was performed, provided or considered:

1. Medical or dental records of the covered person;
2. The consent document signed, or required to be signed, in order to receive the prescribed service or supply;
3. Protocols of the health care provider that renders the prescribed service or prescribes or dispenses the supply;
4. Authoritative peer reviewed medical or scientific writings that are published in the United States regarding the prescribed service or supply for the treatment of the covered person's diagnosis, including, but not limited to

"United States Pharmacopeia Dispensing Information"; and "American Hospital Formulary Service";

5. The published opinions of: the American Medical Association (AMA), or specialty organizations recognized by the AMA; or the National Institutes of Health (NIH); or the Center for Disease Control (CDC); or the Office of Technology Assessment; or, the American Dental Association (ADA), with respect to dental services or supplies.
6. Federal laws or final regulations that are issued by or applied to the FDA or Department of Health and Human Services regarding the prescribed service or supply.
7. The latest edition of "The Medicare National Coverage Determinations Manual."

Full-time permanent employee is a person that meets the County's requirements for full-time permanent status.

Home health agencies are home health care providers, which are licensed according to state and local laws to provide skilled nursing and other services on a visiting basis in your home, and recognized as home health providers under Medicare and/or accredited by a recognized accrediting agency such as the Joint Commission on the Accreditation of Healthcare Organizations.

Home infusion therapy provider is a provider licensed according to state and local laws as a pharmacy, and must be either certified as a home health care provider by Medicare, or accredited as a home pharmacy by the Joint Commission on Accreditation of Health Care Organizations.

Hospice is an agency or organization primarily engaged in providing palliative care (pain control and symptom relief) to terminally ill persons and supportive care to those persons and their families to help them cope with terminal illness. This care may be provided in the home or on an inpatient basis. A hospice must be: (1) certified by Medicare as a hospice; (2) recognized by Medicare as a hospice demonstration site; or (3) accredited as a hospice by the Joint Commission on Accreditation of Hospitals. A list of hospices meeting these criteria is available upon request.

Hospital is a facility that provides diagnosis, treatment and care of persons who need acute inpatient hospital care under the supervision of *physicians*. It must be licensed as a general acute care hospital according to state and local laws. It must also be registered as a general hospital by the American Hospital Association and meet accreditation standards of the Joint Commission on Accreditation of Health Care Organizations.

Infertility is: (1) the presence of a condition recognized by a *physician* as a cause of infertility; or (2) the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception.

Medically necessary procedures, supplies, equipment or services are those the *claims administrator* determines to be:

1. Appropriate and necessary for the diagnosis or treatment of the medical condition;
2. Provided for the diagnosis or direct care and treatment of the medical condition;
3. Within standards of good medical practice within the organized medical community;
4. Not primarily for your convenience, or for the convenience of your *physician* or another provider; and
5. The most appropriate procedure, supply, equipment or service which can safely be provided. The most appropriate procedure, supply, equipment or service must satisfy the following requirements:
    a. There must be valid scientific evidence demonstrating that the expected health benefits from the procedure, supply, equipment or service are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for you with the particular medical condition being treated than other possible alternatives; and
    b. Generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable; and
    c. For *hospital stays*, acute care as an inpatient is necessary due to the kind of services you are receiving or the severity of your condition, and safe and adequate care cannot be received by you as an outpatient or in a less intensified medical setting.

Mental or nervous disorders are conditions that affect thinking and the ability to figure things out, perception, mood and behavior. A mental or nervous disorder is recognized primarily by symptoms or signs that appear as distortions of normal thinking, distortions of the way things are perceived (e.g., seeing or hearing things that are not there), moodiness, sudden and/or extreme changes in mood, depression, and/or unusual behavior such as depressed behavior or highly agitated or manic behavior.

Some mental or nervous disorders are: schizophrenia, manic-depressive and other conditions usually classified in the medical community as psychosis; drug, alcohol and other substance addiction or abuse; depressive, phobic, manic and anxiety conditions (including panic disorders); bipolar affective disorders including mania and depression; obsessive compulsive disorders; hypochondria; personality disorders (including paranoid, schizoid, dependent, anti-social and borderline); dementia and delirious states; post traumatic stress disorder; adjustment reactions; reactions to stress; hyperkinetic syndromes; attention deficit disorders; learning disabilities; conduct disorder; oppositional disorder; mental retardation; autistic disease of childhood; anorexia nervosa and bulimia.

Any condition meeting this definition is a mental or nervous disorder no matter what the cause of the condition may be.

Negotiated rate is the amount *participating providers* agree to accept as payment in full for covered services. It is usually lower than their normal charge. Negotiated rates are determined by Participating Provider Agreements.

Non-participating provider is a *hospital* or *physician* NOT participating in the Prudent Buyer Plan network or does not participate in a Blue Cross and/or Blue Shield Plan network outside California, at the time services are rendered. They are not *participating providers*. Non-participating provider also refers to pharmacies NOT participating in the CVS/Caremark pharmacy network. Remember that only a portion of the amount which a *non-participating provider* charges for services may be treated as *covered expense* under this *plan*. See YOUR MEDICAL BENEFITS: HOW COVERED EXPENSE IS DETERMINED.

Other health care provider is one of the following providers:

1. A certified registered nurse anesthetist;
2. A blood bank;
3. A licensed ambulance company;
4. A *hospice;* or
5. A licensed birth center.

The provider must be licensed according to state and local laws to provide covered medical services.

Participating provider is a *hospital* or *physician* participating in the Prudent Buyer Plan network or participates in a Blue Cross and/or Blue Shield Plan network outside California, at the time services are rendered. Participating provider also refers to pharmacies in the CVS/Caremark pharmacy network. *Participating providers* agree to accept the *negotiated rate* as payment for covered services. A directory of *participating providers* is available upon request.

Physician means:

1. A doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided; or
2. One of the following providers, but only when the provider is licensed to practice where the care is provided, is rendering a service within the scope of that license, and such license is required to render that service, is providing a service for which benefits are specified in this *plan description*, and when benefits would be payable if the services were provided by a physician as defined above:
    a. A dentist (D.D.S. or D.M.D.)
    b. An optometrist (O.D.)
    c. A dispensing optician
    d. A podiatrist or chiropodist (D.P.M., D.S.P. or D.S.C.)
    e. A licensed clinical psychologist
    f. A chiropractor (D.C.)

g. An acupuncturist (A.C.)*
h. A licensed midwife
i. A licensed clinical social worker (L.C.S.W.)
j. A marriage and family therapist (M.F.T.)
k. A physical therapist (P.T. or R.P.T.)*
l. A speech pathologist*
m. An audiologist*
n. A respiratory care practitioner (R.C.P.)*
o. A *psychiatric mental health nurse* (R.N.)*
p. A registered dietitian (R.D.)* for the provision of diabetic medical nutrition therapy only

***Note:** The providers indicated by asterisks (*) are covered only by referral of a physician as defined in 1 above.

Plan is the set of benefits described in this *plan description* and in the amendments to this *plan description*, if any. These benefits are subject to the terms and conditions of the *plan.* If changes are made to the plan, an amendment or revised *plan description* will be issued to each *member* affected by the change.

Plan administrator refers to County of Sonoma, the entity that is responsible for the administration of the *plan.* Direct inquiries to the Benefits Unit at (707) 565-2900 or benefits@sonoma-county.org.

Plan description is this written description of the benefits provided under the *plan*.

Plan year is a 12 month period starting on June 1 at 12:01 a.m. Pacific Standard Time.

Prior plan is a plan sponsored by us that was replaced by this *plan* within 60 days. You are considered covered under the prior plan if you: (1) were covered under the prior plan on the date that plan terminated; (2) properly enrolled for coverage within 31 days of this *plan's* Effective Date; and (3) had coverage terminate solely due to the prior plan's termination.

Prosthetic devices are appliances that replace all or part of a function of a permanently inoperative, absent or malfunctioning body part. The term "prosthetic devices" includes orthotic devices, rigid or semi-supportive devices that restrict or eliminate motion of a weak or diseased part of the body.

Psychiatric health facility is an acute 24-hour facility operating within the scope of a state license, or in accordance with a license waiver issued by the State. It must be:

1. Qualified to provide short-term inpatient treatment according to state law;
2. Accredited by the Joint Commission on Accreditation of Health Care Organizations; and
3. Staffed by an organized medical or professional staff, which includes a *physician* as medical director.

Psychiatric mental health nurse is a registered nurse (R.N.) who has a master's degree in psychiatric mental health nursing, and is registered as a psychiatric mental health nurse with the state board of registered nurses.

Retired employee or Retiree is a former *employee* who meets the eligibility requirements described in HOW COVERAGE BEGINS AND ENDS provision.

Skilled nursing facility is an institution that provides continuous skilled nursing services. It must be licensed according to state and local laws and be recognized as a skilled nursing facility under Medicare.

Special care units are special areas of a *hospital* that have highly skilled personnel and special equipment for acute conditions that require constant treatment and observation.

Spouse is a person that meets the *plan's* eligibility requirements for spouses as outlined under HOW COVERAGE BEGINS AND ENDS.

Stay is inpatient confinement that begins when you are admitted to a facility and ends when you are discharged from that facility.

Subscriber: A *retired employee* or an *employee* who is covered by the plan on his/her own behalf and not by virtue of dependent status.

Totally disabled dependent is a *dependent* who has been determined to be disabled by a physician, based on Social Security criteria.

Totally disabled employee is an *employee* who, because of illness or injury, is unable to work for income in any job for which he/she is qualified or for which they become qualified by training or experience, and who are in fact unemployed.

Urgent care is the services received for a sudden, serious, or unexpected illness, injury or condition, other than one which is life threatening, which requires immediate care for the relief of severe pain or diagnosis and treatment of such condition.

We (us, our) refers to County of Sonoma.

You (your) refers to the *employee* and *dependents* who are enrolled for benefits under this *plan*.

BY THIS AGREEMENT,

County of Sonoma Health Plan

is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for

County of Sonoma

on or as of the day and year first below written.

By: _____
Efren Carillo

Title: Chairman of the Board

Date: 5-24-2011

APPENDIX 1 - COUNTY HEALTH PLAN PPO (CHP PPO)

In addition to dollar and percentage co-pays/co-insurance, members are responsible for deductibles, as described below. Please review the deductible information to know if a deductible applies to a specific covered service. Members are also responsible for all costs over the plan maximums. Plan maximums and other important information appear in *italics.*

SUMMARY OF BENEFITS

Plan Design	Benefit
Deductibles (combined in and out-of-network providers) *For all covered expenses, the member is responsible to satisfy the deductible before the plan pays benefits, unless it is specifically stated the deductible is otherwise waived.*	$300/member; $900/family
Out-of-Pocket Maximums (combined in and out-of-network providers) *Covered expenses (e.g. co-insurance amounts), apply towards out-of-pocket maximum*	$2,000 per member/per year; $4,000 per family/per benefit year
Co-payments, deductibles, and prescription drug co-payments are not applied toward the out-of-pocket maximum. In addition, out-of-pocket costs incurred for non-covered services or supplies in excess of the plan's covered expenses (e.g., expenses incurred for out-of-network services that exceed the reasonable and customary charges allowed by the plan) are not applied toward the out-of-pocket maximum; these non-covered charges are the plan participant's financial responsibility.	After out-of-pocket maximum is reached, the plan pays 100% of covered expenses for the rest of the benefit year.
Lifetime Maximum (combined in and out-of-network providers)	Unlimited
In-Network Providers *Within California: Only within the Anthem Blue Cross PPO Network* *Outside California: Only Blue Cross and Blue Shield Association members that participate in the "Bluecard Program"* **Except for emergencies, services received outside of the Anthem Blue Cross PPO, or Bluecard networks are not covered and the participant will be responsible for all costs incurred.**	

COVERED EXPENSES

APPENDIX 1 - COUNTY HEALTH PLAN PPO PLAN (CHVPP)

Covered Expenses	Benefit
Acupuncture • Attending physician referral required when service is performed by a provider other than an MD for treatment of intractable pain only.	90% co-insurance in-network/ 60% co-insurance out-of-network
Allergy Treatment • Testing, Serum, Injections	90% co-insurance in-network/ 60% co-insurance out-of-network
Ambulance Services • Ground & Air	90% co-insurance in-network/ 60% co-insurance out-of-network *(Emergency ambulance service benefits are paid at 90% co-insurance for out-of-network)*
Blood • Blood transfusions, blood processing & the cost of unreplaced blood & blood products • Autologous blood (self-donated blood collection, testing, processing & storage for planned surgery)	90% co-insurance in-network/ 60% co-insurance out-of-network
Cancer Screening Tests	See Preventive Care
Chemotherapy	90% co-insurance in-network/ 60% co-insurance out-of-network
Chiropractic Services	90% co-insurance in-network/ 60% co-insurance out-of-network
Contraception Services and supplies in connection with the following methods of contraception: • Oral contraceptives (subject to Prescription drug co-pays and not co-insurance) • Injectable drugs/implants, administered in a physician's office, if medically necessary • Intrauterine contraceptive devices (IUD) and diaphragms, dispensed by a physician	90% co-insurance in-network/ 60% co-insurance out-of-network

APPENDIX 1 - COUNTY HEALTH PLAN PPO (CHP PPO)

Covered Expenses	Benefit
Dental Care • Limited to treatment of accidental injury to natural teeth	90% co-insurance in-network/ 60% co-insurance out-of-network
Diagnostic • X-ray, laboratory services, pre-admission testing • Non-routine mammography	90% co-insurance in-network/ 60% co-insurance out-of-network
Durable Medical Equipment (DME) *(pre-authorization required for expenses over $1,000)* • Rental or purchase of DME • Includes pediatric asthma equipment and supplies • Excludes shoes, orthotic devices • Hearing Aids – 1 per ear, every 36 months	90% co-insurance in-network/ 60% co-insurance out-of-network
Hemodialysis Treatment	90% co-insurance in-network/ 60% co-insurance out-of-network
Home Health Care *(preauthorization required)* • Services & supplies from a home health agency	90% co-insurance in-network/ 60% co-insurance out-of-network
Home Infusion Therapy *(preauthorization required)* • Includes medication, ancillary services & supplies; caregiver training & visits by provider to monitor therapy; durable medical equipment; lab services	90% co-insurance in-network/ 60% co-insurance out-of-network
Hospice Care • Inpatient or outpatient services for members limited to $3,000 per lifetime • Inpatient hospice care limit of $150 maximum payable per day • Family bereavement counseling limited to $200 per lifetime	90% co-insurance in-network/ 60% co-insurance out-of-network

APPENDIX 1 - COUNTY HEALTH PLAN PPO (CHP PPO)

Covered Expenses	Benefit
Hospital & Physician Services (Inpatient & Outpatient) *(Pre-authorization required for inpatient services; waived for emergency admissions)* • Medical and non-medical emergencies • Rehabilitation facility services • Semi-private room, meals & special diets, ancillary services • Surgical services & supplies The following services must be pre-authorized: • All inpatient confinements (including hospital, skilled nursing, inpatient rehabilitation facility and mental disorder/ substance abuse treatment confinements) • Organ/ Tissue Transplant Services • Home Health Care Services • Reconstructive Surgery	$100 Emergency Room (waived if admitted as inpatient) $125 Admission Co-pay + 90% co-insurance in-network/ 60% co-insurance out-of-network (90% co-insurance out-of-network for *emergency* treatment obtained in a hospital emergency room) *Covered expenses will be reduced by 50% if timely notification is not received for inpatient confinements, excluding emergency treatment)*
Immunizations Plan covers inoculations and immunizations, with the following limitations: • Diphtheria, pertussis and tetanus (DPT) - once every ten years after pediatric immunization • Polio – once in lifetime after pediatric immunization • Mumps – once if not previously immunized • Rubella – once per lifetime • Gamma globulin- upon recommendation by physician • Hepatitis B – once every 5 years for individuals in a high risk category, subject to pre-authorization	**Deductible Waived** 100% co-insurance in-network/ 60% co-insurance out-of-network
Infertility • Diagnostic services and surgical repair only	90% co-insurance in-network/ 60% co-insurance out-of-network
Maternity & Pregnancy Care *(Services cover employee, spouse or domestic partner)* • Outpatient prenatal/postnatal care physician office visits • Inpatient physician services • Birthing Center • Delivery (surgeon, anesthesiologist) • Newborn routine nursery care • Hospital & ancillary services • Elective abortion *(including physician administered prescription drugs*)	90% co-insurance in-network/ 60% co-insurance out-of-network

APPENDIX 1 - COUNTY HEALTH PLAN PPO (CHP PPO)

Covered Expenses	Benefit
Mental Health Care – Inpatient (*pre-authorization required, waived for emergency admission*)	$125 Admission Co-pay + 90% co-insurance in-network/ 60% co-insurance out-of-network
Mental Health Care – Outpatient - (Provider must be a Psychologist, MFT or LCSW) • Marriage counseling excluded	90% co-insurance in-network/ 60% co-insurance out-of-network
Organ & Tissue Transplants *(preauthorization required)* • Inpatient services provided in connection with non-investigative organ or tissue transplants • Physician office visits (including specialists and consultants) Transportation/Accommodations • $10,000 per transplant benefit period maximum for travel • Daily combined max of $200 for lodging	90% co-insurance in-network/ 60% co-insurance out-of-network 90% co-insurance in-network/ Not covered out-of-network
Physical Therapy • Office visit, inpatient and outpatient • Occupational therapy excluded	90% co-insurance in-network/ 60% co-insurance out-of-network
Physician Service/ Office Visit	In-network $20 co-pay & **Deductible Waived** 60% co-insurance out-of-network, Deductible Not Waived
Prescription Drug • 34 day supply or 100 unit dose • Mandatory generic • Mandatory mail order for maintenance drugs after 2 fills at retail	$5 co-pay generic/ $15 co-pay formulary brand name/ $30 co-pay non-formulary brand name 3 months supply by mail order for one co-payment

APPENDIX 1 - COUNTY HEALTH PLAN PPO (CHP PPO)

Covered Expenses	Benefit
Preventive Care – All Members Age 18 and older • No maximum • Routine physical exams, immunizations, X-ray & lab for routine physical exam o One exam annually • Other routine cancer screening tests. Services and supplies provided in connection with all generally medically accepted cancer screening tests.	In-network No charge **Deductible Waived** Out of network 60% co-insurance Deductible Not Waived
Preventive Care – Men • Routine annual digital rectal exam and prostate antigen test covered for males ages 40 and older • Colorectal cancer screening, including colonoscopy and sigmoidoscopy, for persons age 50 and older every five years	In-network No charge **Deductible Waived** Out of network 60% co-insurance Deductible Not Waived
Preventive Care – Children – Birth to Age 18 • Medical hospital benefits for routine nursery care of a newborn child, if the child's natural mother is an employee, enrolled spouse, or a domestic partner. o Includes expenses incurred for circumcision. • Routine physical examinations, limited to 11 office visits payable during first 30 months of age, then annual office visit payable from age 3 years through age 18 years. • Childhood immunizations that are FDA approved and in accordance with the CDC recommendations for children in the US. • Also, see "Immunizations" for other covered expenses	In-network No charge **Deductible Waived** Out of network 60% co-insurance Deductible Not Waived
Preventive Care – Women Ages 18 and Older • Annual routine pelvic exam, pap smear, breast exam, mammogram	In-network No charge **Deductible Waived** Out of network 60% co-insurance Deductible Not Waived

APPENDIX 1 - COUNTY HEALTH PLAN PPO (CHP PPO)

Covered Expenses	Benefit
Prosthetics • All prosthetic devices including but not limited to: breast prostheses; prosthetic devices to restore a method of speaking; surgical implants; artificial limbs or eyes; & the first pair of contact lenses or eyeglasses when required as a result of eye surgery	90% co-insurance in-network/ 60% co-insurance out-of-network
Radiation Therapy	90% co-insurance in-network/ 60% co-insurance out-of-network
Second Surgical Opinions	90% co-insurance in-network/ 60% co-insurance out-of-network
Surgery *(preauthorization required)* • Inpatient Hospital • Outpatient Hospital • Outpatient Surgery Facility • Physician's Office	90% co-insurance in-network/ 60% co-insurance out-of-network
Skilled Nursing Facility *(preauthorization required)* • Semi-private room, services & supplies • 100 days maximum per plan year per member • No coverage for Medicare members until Medicare benefit is exhausted	90% co-insurance in-network/ 60% co-insurance out-of-network
Speech Therapy • Inpatient, outpatient and office visit speech therapy following injury or organic disease • Lifetime maximum of $1,000 per covered person	90% co-insurance in-network/ 60% co-insurance out-of-network
Substance Abuse Inpatient *(preauthorization required, waived for emergency admissions)*	$125 Admission Co-pay + 90% co-insurance in-network/ 60% co-insurance out-of-network
Substance Abuse Outpatient	90% co-insurance in-network/ 60% co-insurance out-of-network
Sterilization	90% co-insurance in-network/ 60% co-insurance out-of-network
Urgent Care Facility	$20 co-pay in-network/ 60% co-insurance out-of-network

APPENDIX 2 - COUNTY HEALTH PLAN EPO (CHP EPO) 2011-2012

In addition to dollar and percentage co-pays/co-insurance, members are responsible for deductibles, as described below. Please review the deductible information to know if a deductible applies to a specific covered service. Members are also responsible for all costs over the plan maximums. Plan maximums and other important information appear in *italics* Benefits are only available within the Anthem Blue Cross PPO Network within California and outside of California through Blue Cross and Blue Shield Association members that participate in the "Bluecard Program." With the exception of emergencies, there are no out of network benefits, so services received outside of these networks will not be covered and all costs incurred will be the responsibility of the participant.

SUMMARY OF BENEFITS

Plan Design	Benefit (In-Network Only)
Deductibles *For all covered expenses, the member is responsible to satisfy the deductible before the plan pays benefits, unless it is specifically stated the deductible is otherwise waived.*	$500/member; $1,500/family
Out-of-Pocket Maximums *Covered expenses (e.g. co-insurance amounts), apply towards out-of-pocket max.*	$5,000 per member/per year $10,000 per family/per year After out-of-pocket maximum is reached, the plan pays 100% of covered expenses for the rest of the plan year.
Co-payments, deductibles, and prescription drug co-payments are not applied toward the out-of-pocket maximum. In addition, out-of-pocket costs incurred for non-covered services or supplies in excess of the plan's covered expenses (e.g., expenses incurred for out-of-network services that exceed the reasonable and customary charges allowed by the plan) are not applied toward the out-of-pocket maximum; these non-covered charges are the plan participant's financial responsibility	
Lifetime Maximum	Unlimited
Covered Providers *Within California: Only within the Anthem Blue Cross PPO Network* *Outside California: Only Blue Cross and Blue Shield Association members that participate in the "Bluecard Program"* **Except for emergencies, services received outside of the Anthem Blue Cross PPO, or Bluecard networks are not covered and the participant will be responsible for all costs incurred.**	

APPENDIX 2 - COUNTY HEALTH PLAN EPO (CHP EPO)

COVERED EXPENSES

Covered Expenses	Benefit (In-Network Only)
Acupuncture • Physician referral required when service is performed by a provider other than an MD for treatment of intractable pain only.	80% co-insurance
Allergy Treatment • Testing, Serum, Injections	80% co-insurance
Ambulance Services • Ground & Air	80% co-insurance
Blood • Blood transfusions, blood processing & the cost of unreplaced blood & blood products • Autologous blood (self-donated blood collection, testing, processing & storage for planned surgery)	80% co-insurance
Cancer Screening Tests	See Preventive Care
Chemotherapy	80% co-insurance
Chiropractic Services	80% co-insurance
Contraception Services and supplies in connection with the following methods of contraception: • Oral contraceptives (subject to Prescription drug co-pays) • Injectable drugs/implants, administered in a physician's office, if medically necessary • Intrauterine contraceptive devices (IUD) and diaphragms, dispensed by a physician	80% co-insurance

APPENDIX 2 - COUNTY HEALTH PLAN EPO (CHP EPO)

Covered Expenses	Benefit (In-Network Only)
Dental Care • Limited to treatment of accidental injury to natural teeth	80% co-insurance
Diagnostic • X-ray, laboratory services, pre-admission testing • Non-routine mammography	80% co-insurance
Durable Medical Equipment (DME) *(pre-authorization required for expenses over $1,000)* • Rental or purchase of DME • Includes pediatric asthma equipment and supplies • Excludes shoes, orthotic devices • Hearing Aids – 1 per ear, every 36 months	80% co-insurance
Hemodialysis Treatment	80% co-insurance
Home Health Care *(preauthorization required)* • Services & supplies from a home health agency	Not Covered
Home Infusion Therapy *(preauthorization required)* • Includes medication, ancillary services & supplies; caregiver training & visits by provider to monitor therapy; durable medical equipment; lab services	80% co-insurance
Hospice Care • Inpatient or outpatient services for members limited to $3,000 per lifetime • Inpatient hospice care limit of $150 maximum payable per day • Family bereavement counseling limited to $200 per lifetime	80% co-insurance

APPENDIX 2 - COUNTY HEALTH PLAN EPO (CHP EPO)

Covered Expenses	Benefit (In-Network Only)
Hospital & Physician Services (Inpatient & Outpatient) *(Pre-authorization required for inpatient services; waived for emergency admissions)* • Medical and non-medical emergencies • Rehabilitation facility services • Semi-private room, meals & special diets, ancillary services • Surgical services & supplies The following services must be pre-authorized: • All inpatient confinements (including hospital, skilled nursing, inpatient rehabilitation facility and mental disorder/ substance abuse treatment confinements) • Organ/ Tissue Transplant Services • Home Health Care Services • Reconstructive Surgery	$150 co-pay for emergency room, $250 admission co-pay for maternity, $500 Admission co-pay for all other 80% co-insurance after co-pay *Covered expenses will be reduced by 50% if timely notification is not received for inpatient confinements, excluding emergency treatment)*
Immunizations Plan covers inoculations and immunizations, with the following limitations: • Diphtheria, pertussis and tetanus (DPT) - once every ten years after pediatric immunization • Polio – once in lifetime after pediatric immunization • Mumps – once if not previously immunized • Rubella – once per lifetime • Gamma globulin- upon recommendation by physician • Hepatitis B – once every 5 years for individuals in a high riskcategory, subject to pre-authorization	Deductible Waived No co-pay
Infertility • Diagnostic services and surgical repair only	80% co-insurance
Maternity & Pregnancy Care *(Services cover subscriber, spouse or domestic partner)* • Outpatient prenatal/postnatal care physician office visits • Inpatient physician services • Birthing Center • Delivery (surgeon, anesthesiologist) • Newborn routine nursery care • Hospital & ancillary services • Elective abortion *(including physician administered prescription drugs*)	80% co-insurance In hospital services have a $250 co-pay before the plan pays at 80% co-insurance

APPENDIX 2 - COUNTY HEALTH PLAN EPO (CHP EPO)

Covered Expenses	Benefit (In-Network Only)
Mental Health Care – Inpatient (*pre-authorization required, waived for emergency admission*)	80% co-insurance
Mental Health Care – Outpatient (Provider must be Psychiatrist, Psychologist, or Master's level licensed therapist) • Marriage counseling excluded	80% co-insurance
Organ & Tissue Transplants *(preauthorization required)* • Inpatient services provided in connection with non-investigative organ or tissue transplants • Physician office visits (including specialists and consultants) Transportation/Accommodations • $10,000 per transplant benefit period maximum for travel • Daily combined max of $200 for lodging	$500 co-pay + 80% co-insurance 80% co-insurance
Physical Therapy • Office visit, inpatient and outpatient • Occupational therapy excluded	80% co-insurance
Physician Service/ Office Visit	Deductible Waived $50 co-pay
Prescription Drug • 34 day supply or 100 unit dose • Mandatory generic • Mandatory mail order for maintenance drugs after 2 fills at retail	$10 co-pay generic/ $35 co-pay formulary brand name/ $70 co-pay non-formulary brand name 3 months supply by mail order for one co-payment

APPENDIX 2 - COUNTY HEALTH PLAN EPO (CHP EPO)

Covered Expenses	Benefit (In-Network Only)
Preventive Care – All Members Age 18 and older • No maximum • Routine physical exams, immunizations, X-ray & lab for routine physical exam, routine cancer screening test(s) o One exam annually • Other routine cancer screening tests. Services and supplies provided in connection with all generally medically accepted cancer screening tests.	Deductible Waived No charge
Preventive Care – Men • Routine annual digital rectal exam and prostate antigen test covered for males ages 40 and older • Colorectal cancer screening, including colonoscopy and sigmoidoscopy, for persons age 50 and older every five years	Deductible Waived No charge
Preventive Care – Children – Birth to age 18 • Medical hospital benefits for routine nursery care of a newborn child, if the child's natural mother is an employee, enrolled spouse, or a domestic partner. • Includes expenses incurred for circumcision. • Routine physical examinations, limited to 11 office visits payable during first 30 months of age, then annual office visit payable from age 3 years through age 18 years. • Childhood immunizations that are FDA approved and in accordance with the CDC recommendations for children in the US. • Also, see "Immunizations" for other covered expenses	Deductible Waived No charge
Preventive Care – Women Ages 18 and Older • Annual routine pelvic exam, pap smear, breast exam, mammogram	Deductible Waived No charge

APPENDIX 2 - COUNTY HEALTH PLAN EPO (CHP EPO) 2011-2012

Covered Expenses	Benefit (In-Network Only)
Prosthetics • All prosthetic devices including but not limited to: breast prostheses; prosthetic devices to restore a method of speaking; surgical implants; artificial limbs or eyes; & the first pair of contact lenses or eyeglasses when required as a result of eye surgery	80% co-insurance
Radiation Therapy	80% co-insurance
Second Opinions	80% co-insurance
Surgery *(preauthorization required)* • Inpatient Hospital • Outpatient Hospital • Outpatient Surgery Facility • Physician's Office	$500 co-pay + 80% co-insurance
Skilled Nursing Facility	Not covered
Speech Therapy • Inpatient, outpatient and office visit speech therapy following injury or organic disease • Lifetime maximum of $1,000 per covered person	80% co-insurance
Substance Abuse Inpatient *(preauthorization required, waived for emergency admissions)*	80% co-insurance
Substance Abuse Outpatient	80% co-insurance
Sterilization	80% co-insurance
Urgent Care Facility	$50 copay